beyondblue
Depression. Anxiety.

What works to promote emotional wellbeing in older people

A guide for aged care staff working in community or residential care settings

Yvonne Wells: with Sunil Bhar, Glynda Kinsella, Catherine Kowalski, Monika Merkes, Allison Patchett, Barbara Salzmann, Karen Teshuva and John van Holsteyn

www.beyondblue.org.au 1300 22 4636

About the authors

Yvonne Wells, Catherine Kowalski, Monika Merkes, Karen Teshuva and John van Holsteyn are staff of the Australian Institute for Primary Care and Ageing (AIPCA) at La Trobe University.

Glynda Kinsella is Director of postgraduate programs in the School of Psychological Sciences at La Trobe University.

Sunil Bhar is a senior lecturer in psychology at Swinburne University.

Allison Patchett is General Manager, Innovation and Development, at Uniting AgeWell.

Barbara Salzmann (formerly Parker, formerly of La Trobe University) is Senior Research Officer at SuperFriend – IFF Mental Health Foundation.

Acknowledgements

Thanks to Nancy Pachana and Gerard Byrne (University of Queensland), Roderick McKay (University of NSW), Bernie McCarthy (McCarthy Psychology Services) and Rosanne Fleming (Fleming Care) for their assistance as members of our expert panel.

Thanks to the many other people who assisted this project by piloting this booklet within their organisations, including Benetas, Brotherhood of St Laurence, City of Ballarat, City of Whitehorse, Millmerran Centenary Retirement Village, South East and Illawarra Area Health Service, St Paul de Chartres, SuperFriend and Uniting AgeWell.

Images

Thanks to Uniting AgeWell for providing the images on pages 23, 25, 29, 50, 53, 60, 62, 65, 78, 81, 92, and 97. Thanks to Rajiv Khosla, La Trobe University, for permission to use the image on 86, to ACH Group for the image on page 55, Feros Care for the image on page 67, Humour Foundation for the image on page 34, Alzheimer's Australia Tas for the image on page 47, Amana Living on page 51 and the Delta Society for the image on page 59.

Case studies

Thank you to the Victorian Department of Health (DH) and Uniting AgeWell for providing many of the case studies in this booklet. The Victorian DH case studies were taken from the Well for Life resource and ASM Prepare. A full list of case study sources is provided on page 136.

Suggested citation: Wells, Y., Bhar, S., Kinsella, G., Kowalski, C., Merkes, M., Patchett, A., Salzmann, B., Teshuva, K., & van Holsteyn, J. (2014). *What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care settings.* Melbourne: *beyondblue.*

ISBN: 978-1-921821-08-0

Contents

Introduction

This booklet has been designed for staff working in community or residential aged care services. It covers a range of interventions that can be used to promote emotional wellbeing or to help people with anxiety or depression. These interventions are grouped by type, for example, physical activity interventions, and interventions to do with music and the arts.

Some interventions are supported by a lot of scientific evidence, but others are not. This booklet summarises the strength of evidence for the use of each intervention in each setting, and whether its usefulness has been shown for promoting emotional wellbeing, as well as specifically for anxiety and depression. Most sections include a short case study to demonstrate how the interventions may be used with older people in aged care settings.

The booklet also includes a list of interventions that staff may want to consider if their clients or residents have dementia or memory loss.

Finally, this booklet provides some advice to community and residential care staff on how to plan an evaluation of whether or not an intervention has made a difference.

The booklet focuses on psychosocial interventions that can be used in community settings or residential care. Psychosocial interventions include any interventions that emphasise psychological or social approaches, rather than biological interventions such as medications. For information about neurobiological and pharmaceutical treatments, go to **www.beyondblue.org.au/resources**

What is emotional wellbeing?

Emotional wellbeing includes satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support.

The Well for Life resource published by the Victorian government identifies five components crucial to maintaining an individual's emotional wellbeing:

1. Resilience and coping
2. Being productive and making a contribution
3. Social connections
4. Basic needs and comfort
5. Enjoying sensory enrichment.

Social and emotional wellbeing are often grouped together: being socially and emotionally well means being able to make the most of your abilities, cope with the normal stresses of life, and contribute to your community. For people of working age, it also includes working productively.

Australian Unity and Deakin University have researched emotional wellbeing in Australia for over 10 years. The Australian Unity Wellbeing Index measures subjective wellbeing and our national and personal satisfaction with life. Their report defines subjective wellbeing as a normally positive state of mind. It is a long-lasting, deep sense of contentment. Generally, people's sense of wellbeing is stable. It is only when the challenges in life become overwhelming that our psychological stability fails and our happiness suffers. Normally this loss of happiness is short-term, but if it is prolonged and fails to recover, it can result in depression.

You can download the Well for Life resource at www.health.vic.gov.au/agedcare and find out more about the Australian Unity Wellbeing Index at www.australianunity.com.au

For information about promoting wellbeing in Indigenous Australians, visit www.healthinfonet.ecu.au

What are anxiety and depression?

Anxiety is more than just feeling stressed or worried. For a person experiencing anxiety, anxious feelings cannot be brought under control easily. Anxiety is a serious condition that makes it hard for a person to cope with daily life.

Depression is more than just a low mood – it's a serious condition that has an impact on both physical and mental health.

How common are anxiety and depression?

Anxiety and depression are common in Australia. In any one year, over 2 million Australian adults have anxiety and around 1 million have depression. In older Australians, while the precise rates of anxiety and depression are not yet known, it is thought that about 10 per cent of older people in the community experience anxiety and 10–15 per cent experience depression.[1]

Rates of depression in older people in the community who are frail and need support to remain at home are much higher than those of their healthier counterparts. Rates of depression among people living in residential aged care facilities are even higher. An Australian study found that nearly 35 per cent of people living in residential care facilities were depressed.[2]

Less research has been done into anxiety but studies from the Netherlands found that about 6 per cent of older people in residential aged care have anxiety, while 30 per cent have some symptoms of anxiety.[3]

Rates of anxiety and depression are also quite high in particular groups of older people living in the community. For example, the spouses of people with dementia have a fourfold higher risk of a diagnosis of depression than the spouses of people who do not have dementia.[4]

While anxiety and depression are different conditions, they share many causes and some symptoms, and it is not uncommon for anxiety and depression to occur together.[5]

How do you know if an older person has anxiety?

The symptoms of anxiety can often develop gradually over time. Given that we all experience some anxiety, it can sometimes be hard to know how much is too much. To be diagnosed, the anxiety must have a disabling impact on the person's life.

There are many different types of anxiety. While the symptoms for each condition are different, some common symptoms are listed opposite.

Common symptoms of anxiety

Behaviour

- withdrawing from or avoiding situations that cause anxiety
- urges to perform certain rituals to try and relieve anxiety
- not being assertive (i.e. avoiding eye contact)
- difficulty making decisions
- being startled easily

Physical symptoms

- increased heart rate/racing heart
- shortness of breath
- vomiting, nausea or stomach pain
- muscle tension and pain (e.g. sore back or jaw)
- feeling detached from your physical self or surroundings
- having trouble sleeping (e.g. difficulty falling or staying asleep)
- sweating, shaking
- feeling dizzy, lightheaded or faint
- numbness or tingling
- hot or cold flushes

Feelings

- overwhelmed
- fear (particularly when having to face certain objects, situations or events)
- worried about physical symptoms (e.g. fearing there is an undiagnosed medical problem)
- dread (e.g. that something bad is going to happen)
- constantly tense, nervous or on edge
- uncontrollable or overwhelming panic

Thoughts

- "I'm going crazy."
- "I can't control myself."
- "I'm about to die."
- "People are judging me."
- having upsetting dreams or flashbacks of a traumatic event
- finding it hard to stop worrying
- unwanted or intrusive thoughts
- having trouble concentrating

There has been little research into anxiety in older people. Anxiety is treatable and effective treatments are available. The earlier a person seeks help and gets the right treatment, the sooner he or she can recover.

How do you know if an older person has depression?

Depression in older people may occur for a range of different reasons. Sadness is common in older people who experience the onset of a physical illness or personal loss, but depression is different and is not a normal part of ageing.

An older person may be depressed if, for more than two weeks, they have felt down, sad or miserable most of the time, or if they have lost interest or pleasure in most of their usual activities, and if they have experienced symptoms such as those listed opposite.

Everyone experiences some of these symptoms from time to time, and having some symptoms may not necessarily mean a person is depressed. Equally, not every person who is experiencing depression will have all of these symptoms. When symptoms are severe or long-lasting, it's time to get professional help.

Another consideration is that older people may use different words to refer to their depression. Instead of describing 'sadness', for example, they may talk about 'their nerves'.

Dementia can also co-exist with and mask depression, and a thorough assessment is recommended.

Common symptoms of depression

Behaviour

- not going out anymore
- not getting things done at work/school
- withdrawing from close family and friends
- relying on alcohol and sedatives
- not doing usual enjoyable activities
- being unable to concentrate

Thoughts

- "I'm a failure."
- "It's my fault."
- "Nothing good ever happens to me."
- "I'm worthless."
- "Life's not worth living."
- "People would be better off without me."

Feelings

- overwhelmed
- guilty
- irritable
- frustrated
- lacking in confidence
- unhappy
- indecisive
- disappointed
- miserable

Physical symptoms

- tired all the time
- sick and run down
- headaches and muscle pains
- churning gut
- sleep problems
- loss or change of appetite
- significant weight loss or gain

What if the older person has dementia or memory problems?

According to the Australian Institute of Health and Welfare, in 2011, 10 per cent of all Australians aged 65 and over have dementia. 70 per cent of people with dementia live in the community and just over 50 per cent of permanent residents in aged care have dementia.[6] It is anticipated that by 2050, the number of people with dementia will triple. Further, having dementia is a risk factor for developing depression. Therefore, it is important that we also consider interventions that are appropriate for people with dementia in residential and community settings.

Identifying depression in someone with dementia can be difficult, as some of the symptoms are the same, for example:

- apathy
- loss of interest in activities and hobbies
- social withdrawal
- isolation
- trouble concentrating
- impaired thinking.

People living with dementia may have difficulty articulating sadness, hopelessness, guilt and other feelings associated with depression.

In people with dementia, the symptoms of depression may come and go, and they are less likely than other people with depression to talk of suicide. There are formal guidelines for diagnosing depression in people with Alzheimer's disease. They have less emphasis on verbal expression and include irritability and social isolation.

Some people with dementia may become worried and anxious, but are unable to say what is upsetting them. The person may be restless and pace or fidget. It can sometimes seem as if they are stuck in a groove and unable to move on. They may cling if a carer attempts to leave the room. Another common anxious behaviour is shadowing – following a carer closely around the house like a shadow. Some family carers have described how distressing it is to be shadowed constantly, unable to find any privacy.

Sometimes these behaviours are caused by changes in the person's brain, but in other instances, events or factors in the environment may be triggering the behaviour. Sometimes a task may be too complex, or the person may be in pain or not feeling well. A person with dementia may feel pressured because they can no longer cope with everyday demands and worry about doing something incorrectly. They can also become anxious if they attempt a task and fail.

What puts an older person at risk of anxiety or depression?

- An increase in physical health problems or chronic conditions, such as heart disease, stroke or Alzheimer's disease
- Chronic pain
- Side-effects from medications
- Losses such as relationships, independence, work and income, self-worth, mobility and flexibility
- Social isolation
- Significant changes in living arrangements, such as moving from home into a care setting
- Admission to hospital
- Grief and loss, including particular anniversaries and the memories they evoke.

Early detection and treatment may help to keep anxiety and depression from becoming severe. Anxiety and depression are treatable and effective treatments are available.

Preventing anxiety and depression from developing or worsening

Research suggests that we can look after our wellbeing by:

- staying in touch with family and friends
- getting involved in our community
- participating in enjoyable activities that provide a sense of achievement
- finding a balance between work and leisure
- keeping healthy – by eating well and exercising.

People with some symptoms of anxiety and depression can be helped to avoid their condition becoming more serious with exercise, relaxation, social support, useful reading materials and advice, and help to solve their problems. People who are entering residential care may be helped by programs that assist them to become comfortable with their new environment and to foster new relationships.

Prevention of anxiety and depression is important. Studies in many countries have shown that suicide rates are relatively high in older people. A review of programs to reduce suicide risk has shown that interventions can be effective, through addressing the risk factors for depression and social isolation and improving a person's resilience. Having a personal treatment plan and regular follow-up are important.

What if an older person develops anxiety or depression?

The encouraging news is that a range of treatments, health professionals and services is available to help with anxiety and depression, and there are many things that people with anxiety or depression can do to help themselves.

Different types of depression – and different types of anxiety – require different types of treatment. These may include lifestyle changes (such as diet and physical exercise) for preventing and treating mild symptoms of anxiety or depression, through to psychological treatment and drug treatments for moderate to severe levels of anxiety and/or depression.

Anxiety and depression must be recognised in order to be treated. The key to successful treatment is an appropriate assessment by a doctor or other health professional. Both family and professional carers are an invaluable source of information about what changes they may have noticed and should be included in discussions where possible.

Psychological treatments are available and are described briefly in this booklet. Medications for anxiety or depression are often prescribed alongside psychological treatments. Making a decision about which medications to use is complex and requires careful assessment and consideration, taking into account possible side-effects.

For more information about pharmaceutical treatments, see *beyondblue*'s *What works for depression?* and *What works for anxiety?* booklets available at **www.beyondblue.org.au/resources**

Getting help for older people with anxiety or depression

People without specialist qualifications can assist older people with symptoms of anxiety or depression. However, older people with severe problems will probably need professional support. Several types of health professionals can provide help with anxiety or depression. Getting professional support for older people need not be expensive, and some interventions with individuals or groups attract Medicare rebates.

A General Practitioner (GP) is the best starting point for someone seeking professional help. A GP can make a diagnosis, check for any health problems or medications that may be contributing, discuss available treatments, and provide referrals to a mental health specialist such as a psychologist or psychiatrist.

Psychologists are mental health professionals who provide psychological therapies such as cognitive behaviour therapy (CBT) and interpersonal therapy (IPT). Clinical psychologists specialise in the assessment, diagnosis and treatment of mental health conditions. Psychologists and clinical psychologists are not doctors and cannot prescribe medication in Australia. It is not necessary to have a referral from a GP or psychiatrist to see a psychologist.

Psychiatrists are doctors who have undergone further training to specialise in mental health. They can make medical and psychiatric assessments, conduct medical tests, provide therapy and prescribe medication. Psychiatrists often use psychological treatments such as cognitive behaviour therapy (CBT) and interpersonal therapy (IPT), by themselves or with medication. If the depression is severe and hospital admission is required, a psychiatrist will be in charge of the person's treatment. A referral from a GP is needed to see a psychiatrist.

Mental health nurse practitioners are specially trained to care for people with mental health conditions. They work with psychiatrists and GPs to review the state of a person's mental health and monitor their medication. They can also provide information about mental health conditions and treatment. Some mental health nurse practitioners have training in psychological therapies.

Social workers in mental health can support people with anxiety and depression by helping them find ways of effectively managing the situations that trigger these conditions. These may include family issues, financial problems and living arrangements. Mental health social workers can also provide focused psychological self-help strategies, which include relaxation training and skills training (e.g. problem solving and stress management).

Occupational therapists in mental health help people who have difficulty functioning because of a mental health condition to participate in normal, everyday activities. They can also provide focused psychological self-help strategies.

Aboriginal and Torres Strait Islander mental health workers are health workers who understand the mental health issues of Indigenous people and what is needed to provide culturally-safe and accessible services. Some workers may have undertaken training in mental health and psychological therapies. Support provided by Aboriginal and Torres Strait Islander mental health workers might include, but not be limited to, case management, screening, assessment, referrals, transport to and attendance at specialist appointments, education, improving access to mainstream services, advocacy, counselling, support for family and acute distress response.

A counsellor can talk through different problems a person may be experiencing and assist with possible solutions. This may include providing referral options to trained mental health professionals in the local community. While there are many qualified counsellors who work across different settings, some counsellors are less qualified than others and may not be registered. Unfortunately, anyone can call themselves a 'counsellor', even if they don't have training or experience. For this reason, it is important to ask for information about the counsellor's qualifications and whether they are registered with a state board or a professional society. A good counsellor will be happy to provide you with this information.

There are also many **alternative and complementary treatment approaches** for anxiety and depression. Some services may be covered by private health insurance. When seeking a complementary treatment, it is best to check whether the practitioner is registered by a state Registration Board or a professional society. Make sure the practitioner uses treatments that are supported by evidence that shows they are effective.

Rural or remote areas

Older people living in rural and remote communities may find it difficult to access the mental health professionals listed here. If a General Practitioner or other mental health professional is not readily available, there are a number of help and information lines that may be able to assist and provide information or advice. For people with internet access, it may also be beneficial in some cases to try online e-therapies. Several online resources are available, including:

- www.mindspot.org.au
- www.anxietyonline.org.au
- https://ecouch.anu.edu.au/welcome

How to use this booklet

Many different approaches are used to improve wellbeing and treat anxiety and depression. These include medical treatments (such as medications or medical procedures), psychological therapies (including 'talking therapies') and self-help (such as complementary and alternative therapies or lifestyle approaches).

All of the approaches included in this booklet have been investigated as possible ways to assist older people with symptoms of anxiety or depression – see 'How this booklet was developed' on page 13. However the amount of evidence supporting the effectiveness of each intervention can vary greatly.

This booklet provides a summary of what the scientific evidence says about each approach. We have rated the evidence for the effectiveness of each intervention covered in this booklet by using a 'thumbs up' scale:

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Each approach is rated for its impact on emotional wellbeing, anxiety and depression, in both community and residential aged care settings.

When an intervention has been shown scientifically to work, this does not mean it will work equally well for every person. While it might work for the average person, some people will have complications or side-effects, or the intervention will not fit with their lifestyle. Even when an intervention is shown by research to have some effect, this does not mean it is available. On the other hand, some interventions are not easily assessed using scientific trials and there may be little evidence to support them, but they may still be suited to particular individuals. The best strategy is to try an approach that works for most people and one that you are comfortable with. If you experience problems with the treatment, then try another. Sometimes there is no substitute for the advice of a mental health professional, who can advise on the best available treatment options.

Another factor to consider is beliefs. A treatment is more likely to work if a person believes in it and is willing to commit to it. Even the most effective treatments will not work if they are used sometimes or half-heartedly. Some people have strong beliefs about particular types of treatment. For example, some do not like taking medications in general, whereas others have great faith in medical treatments. However, strong belief in a particular approach may not be enough, especially if there is no good evidence that the treatment works.

This booklet provides a summary of what the scientific evidence says about different approaches that have been studied to see if they improve emotional wellbeing or reduce anxiety and depression. It is meant to be picked up and browsed through, rather than read from cover-to-cover.

Links to additional information about many of the interventions in this booklet can be found at **www.beyondblue.org.au/whatworkslinks**

The reviews in this booklet are divided into the following sections:

Physical activity

Relaxation

Sensory stimulation

Music and arts

Social activities

Reflection

Education and skills training

Interventions that rely on technology

Quality of life approaches

Interventions for carers

Interventions delivered by mental health professionals

Of course, some interventions could easily be included in two or more sections. An intervention based on dance, for example, could be categorised as a physical activity, as an artistic expression, or as a social activity.

Within each of these areas, we reviewed the scientific evidence for each intervention to determine its effectiveness with older people in a community or residential aged care setting. Wherever possible, we have highlighted where interventions have been tried with people with dementia or cognitive impairment.

The section 'Interventions for carers' is included because family carers are a special needs group in community services. Interventions to improve carers' emotional wellbeing are rated only for community settings. Most studies on carers have focused on people caring for someone living with dementia, and there is comparatively little evidence on supporting other groups. Many studies include both spouse and adult child carers. Because the focus of this booklet is on supporting older people, studies were included in the review only if they focused on spouse carers or if over half of their participants were older people.

The section on interventions delivered by mental health professionals has been included so that you can get a sense of the range of therapies that may be used with older people.

How this booklet was developed

Searching the literature

To produce these reviews, the scientific literature was searched systematically on the following online databases: the Cochrane Library, PubMed, PsycINFO and Web of Science. We included only studies or reviews published since 2003 because we wanted to summarise the most recent evidence, and we included only studies with a focus on older people, defined as aged 65 years and older. We looked for studies of older people living in the community and those living in residential care that aimed to improve emotional wellbeing or where measures of anxiety or depression were used to evaluate the intervention. We also included some studies where behavioural measures of wellbeing, such as agitation, were used.

Evaluating the evidence

Often, studies are excluded from reviews if they involve people who have not been diagnosed as having anxiety or depression, or if the evidence for their use does not reach the highest scientific standards. For example, studies may be considered adequate only if they have an appropriate comparison group and participants are allocated randomly to either the comparison or intervention group. A recent systematic review or meta-analysis – a study combining the results of several previous studies – is often used as the basis for drawing conclusions.

We began from this point, but we also wanted to be able to reflect practice wisdom in the aged care field and to include studies such as case studies or qualitative studies that would not meet strict scientific criteria. This is because the number of studies carried out with older people in community or residential aged care is relatively small, and the evidence base for many interventions can best be described as emerging. In addition, staff working in these settings may try out interventions to see whether they work, but have few resources to evaluate their work formally or not know how to go about it. Such practice wisdom may carry some weight where the formal evidence is sparse or missing altogether.

In this booklet we summarise the evidence for each intervention, list some important considerations if you are thinking of using it, and provide a case study that may help you to see how the intervention might work in practice. Online resources have also been included.

What to do before you start

Before you start, it is important to carry out an assessment of the people you will be using the intervention with and to plan your evaluation strategy.

When planning an intervention, eight important areas should be assessed.

Cognitive capacity	Does the older person have the thinking, memory and attention skills required for the intervention? If not, could you modify it to suit the client? For example, if the older person has some cognitive impairment you may use memory cues, visual aids, audio recordings, other people, or provide shorter sessions.
Physical capacity	Does the older person have the physical abilities needed to participate? For example, while exercise, relaxation and bibliotherapy can be helpful, they may not be feasible for individuals who are very frail, hearing impaired or visually impaired respectively. Interventions need to be modified to suit the individual.
Treatment history	Ask questions such as "Have you experienced this before?" and "How helpful was it?" Some clients may have had a negative experience with an intervention in the past and prefer not to use it again. Some older people may be able to explain what was unhelpful about past interventions. By assessing the person's history, you can tailor the intervention to the individual.
Client preference	You may present the individual with a choice of interventions, and ask for their preference. For example, you may say – "You can feel better by learning some relaxation skills, going for a short walk or talking to someone about your feelings. What appeals to you most?" The answer will help you identify interventions that are preferred by the client.
Client expectation	Clients can have a stereotype about how useful an intervention will be, and these stereotypes can influence the individual's engagement. For example, some clients believe that simply 'talking' does not work, while others believe that relaxation and 'new age' treatments, such as meditation, are dangerous. By asking the client about their expectations of treatment, you may be able to provide accurate information about an approach, or select a more acceptable treatment.

Client motivation	Some treatments require persistence to be effective. Usually, clients who are very motivated to get better experience more benefits from interventions. Clients who feel ambivalent about their need for help may not persist with the intervention. Ask questions that would allow you to determine if an individual feels ready to participate. For example, ask, "Do you have any concerns about this intervention?" and "How ready do you feel to start?" This assessment will allow you to select interventions to match the individual's stage of readiness.
Severity of symptoms	Compared to talking treatments, treatments that are more action-oriented (such as exercise) can be more suitable for individuals who are experiencing high levels of distress. Ask the client to rate how bad things are for them currently. This will help you decide whether to use interventions that rely on talking versus those that rely on behaviours.
Client personality and culture	Your client may be uncomfortable in large groups, suspicious of other people's motives, or unassertive in expressing their likes and dislikes, or they may dominate the conversation. You could modify your intervention to make the client feel more comfortable. For example, for clients who are suspicious, you may need to explain repeatedly why you are asking them to do certain tasks. One-on-one activities may be preferable for people who are uncomfortable in social situations. You can learn about a client's personality by being watchful and curious about their interactions with you and others and about their enthusiasm or reluctance to engage with interventions.

An important part of implementing any strategy to assist your clients and residents is to plan an evaluation. Help on how to evaluate your interventions is provided on page 124.

A summary of what works for emotional wellbeing in older people

The following table summarises our conclusions about the interventions that are described in this booklet.

	Interventions for use in community settings			Interventions for use in residential care settings		
	Wellbeing	Anxiety	Depression	Wellbeing	Anxiety	Depression
Physical activity						
Exercise	👍👍👍	?	👍👍👍	👍👍👍	👍👍👍	👍👍👍
Gardening and nature-assisted therapy	👍👍👍	?	👍👍👍	👍👍👍	?	👍👍👍
Laughter therapy and laughter yoga	👍👍👍	?	?	👍👍👍	?	?
Tai chi and qigong	👍👍👍	👍👍👍	👍👍👍	👍👍👍	?	?
Yoga	👍👍👍	👍👍👍	👍👍👍	👍👍👍	?	👍👍👍
Relaxation						
Humour therapy	?	?	?	👍👍👍	?	?
Massage	?	?	?	👍👍👍	👍👍👍	?
Meditation	👍👍👍	👍👍👍	👍👍👍	👍👍👍	👍👍👍	?
Reiki	👍👍👍	👍👍👍	👍👍👍	?	?	?
Relaxation training	👍👍👍	👍👍👍	👍👍👍	?	?	?
Sensory stimulation						
Aromatherapy	?	?	?	👍👍👍	👍👍👍	👍👍👍
Bright light therapy	?	?	?	👍👍👍	?	👍👍👍
Snoezelen	?	?	?	👍👍👍	👍👍👍	👍👍👍
Music and arts						
Art therapy and craft	👍👍👍	?	👍👍👍	👍👍👍	?	👍👍👍
Dance and movement	👍👍👍	?	👍👍👍	👍👍👍	?	👍👍👍
Music and singing	👍👍👍	👍👍👍	👍👍👍	👍👍👍	👍👍👍	👍👍👍

	Interventions for use in community settings			Interventions for use in residential care settings		
	Wellbeing	Anxiety	Depression	Wellbeing	Anxiety	Depression
Social activities						
Animals and pet therapy	👍	?	?	👍👍	?	👍👍
Buddying and befriending	👍	?	👍	?	?	?
Intergenerational programs	👍	?	?	?	?	?
Men's sheds	👍	👍	👍	👍	👍	👍
Volunteering	👍	?	👍	?	?	?
Reflection						
Life review	👍👍👍	?	👍👍	👍👍👍	?	👍👍👍
Prayer and spiritual counselling	?	?	?	👍	?	👍
Simple reminiscence	?	?	?	👍👍👍	?	👍👍👍
Education and skills training						
Bibliotherapy and self-help	👍👍👍	?	👍👍	?	?	?
Cognitive and memory skills interventions	👍👍	👍	👍👍	?	?	?
Interventions that rely on technology						
Computer-aided therapy and computer games	👍👍👍	👍👍👍	👍👍👍	👍👍👍	?	👍👍👍
Phone and telemonitoring	👍👍	?	?	?	?	?
Robot companion	?	?	?	👍	?	?
Simulated presence therapy	?	?	?	👍👍	?	?

	Interventions for use in community settings			Interventions for use in residential care settings		
	Wellbeing	Anxiety	Depression	Wellbeing	Anxiety	Depression
Quality of life approaches						
Behavioural activation and pleasant events						
Dementia care mapping						
Person-centred care						
Restorative approaches						
Interventions for carers						
Education, social support and skill building						
Interventions that rely on technology						
Mindfulness-based approaches						
Psychological interventions and counselling						
Mixed interventions						
Interventions delivered by mental health professionals						
Acceptance and commitment therapy						
Cognitive behaviour therapy						
Interpersonal psychotherapy						
Life review therapy						
Mindfulness-based approaches						
Narrative therapy						
Problem-solving therapy						

In general, much more research has been carried out on interventions to reduce symptoms of depression than symptoms of anxiety in older people, and more in community settings than in residential care. The exception is interventions designed to assist people living with dementia, which have been evaluated more in residential care than community settings.

While we have examined single approaches in this booklet, combined approaches to improving the emotional wellbeing of older people may well be a better approach, as is shown by research on older family carers. Combined approaches may be tuned to individuals' needs and preferences and include a mixture of pharmaceutical and psychosocial interventions.

References

1. Haralambous, B. (2009). *Depression in older age: A scoping study.* Final Report. Melbourne: *beyondblue* and NARI.
2. Snowden, J., & Fleming, R. (2008). Recognising depression in residential facilities: An Australian challenge. *International Journal of Geriatric Psychiatry,* 23, 295-300.
3. Smalbrugge, M., Pot, A.M., Jongenelis, K., et al. (2005). Prevalence and correlates of anxiety among nursing home patients. *Journal of Affective Disorders,* 88, 145-153.
4. Joling, J. K., van Hout, H. P. J., Schellevis, F. G., et al. (2010). Incidence of depression and anxiety in the spouses of patients with dementia: A naturalistic cohort study of recorded morbidity with a 6-year follow-up. *American Journal of Geriatric Psychiatry,* 18, 146-153.
5. Beekman, A. T. F., de Beurs, E., van Balkom, et al. (2010). Anxiety and depression in later life: Cooccurrence and communality of risk factors. *American Journal of Psychiatry,* 157, 89-95.
6. Australian Institute of Health and Welfare 2012. *Dementia in Australia.* Cat. no. AGE 70. Canberra: AIHW.

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Physical activity

Exercise

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	👍
Depression	👍👍👍	👍👍

What is it?

The two main types of exercise are aerobic (which exercises the heart and lungs, such as in jogging) and anaerobic (which strengthens muscles, such as in weight training).

How is it meant to work?

Exercise is known to be helpful for overall wellbeing and to treat mild anxiety and depression, but how it works is not clear. It may work by:

- improving sleep patterns
- changing levels of chemicals in the brain, such as serotonin, endorphins or stress hormones
- interrupting negative thoughts that make depression worse
- increasing perceived coping ability by learning a new skill
- socialising with others, if the exercise is done in a group
- distracting people from worries.

Exercise can cause physical symptoms similar to panic attacks (e.g. shortness of breath). This can be helpful for panic disorder because the symptoms of a panic attack are experienced in a controlled way.

Does it work?

Several good quality studies and reviews are available to support the use of exercise interventions in older people. Studies have found short-term positive outcomes for treating depression or reducing symptoms of depression in a majority of studies. Medium- to long-term effects of the intervention are not clear. Exercise has also been shown to reduce the risk of developing anxiety and depression.

Exercise may have extra benefits for older people. The results of a walking program in Japan showed improvements in word fluency related to the brain's frontal lobe function, quality of life, functional capacity including social interaction, and motor function. Another study found that a group exercise program for older women improved self-esteem as well as body strength, flexibility, and balance.

One study in a residential care setting explored the use of moderate intensity, chair-based exercise to reduce anxiety and depression in people with dementia. Levels of anxiety and depression decreased over time in participants, but this study did not include a comparison group.

In contrast, a recent Australian study in a community setting found no impact of exercise on anxiety, depression, or overall wellbeing. This lack of positive outcomes was explained by inability to monitor participants' adherence to the program.

Considerations

It is important to target the program to the group's interests and motivations. Older people's physical limitations need to be considered.

Leading a group-based exercise class for older people safely requires appropriate training. However, no special skills are required to enjoy walking or other easy exercise with clients or residents, if within the older person's capacity. Exercise can be undertaken with people sitting in chairs, to help them stretch, breathe and move. Staff can promote participation and add to people's enjoyment by using music and colourful equipment such as large balloons.

Recommendation

Physical exercise programs in community and residential settings have a wide range of physical and cognitive benefits, and can reduce the symptoms of depression in older people. Exercise may be a suitable intervention for older people living with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

A residential care service worked with residents to involve them in the planning and direction of an exercise program. Previously, attendance had been low and silence preceded the start of the class. Now while waiting, residents hold lively conversations and discuss the day's activities. The session is longer, and residents now encourage each other and require less encouragement from staff. As one person stated: "Participating in the exercise program takes away my stiffness and relaxes me. I like it and I'm pleased to be in it. … It's a good chance to socialise."

Gardening and nature-assisted therapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	👍👍👍	👍👍👍

What is it?

Gardening is the practice of growing and cultivating plants. Nature-assisted therapy (NAT) is based on the understanding that there is an innate connection between humans and nature. NAT attempts to promote health and prevent illness through engagement with the natural environment.

How is it meant to work?

Gardening is thought to promote relaxation and stress relief through engagement with the natural environment. NAT also acknowledges links between human health and the natural environment. NAT encompasses a broad range of techniques such as therapeutic horticulture, which may involve meditation gardens or plant care and cultivation as well as wilderness or outdoor programs designed to re-establish a connection with the natural environment.

Does it work?

We do not have much evidence on whether gardening reduces symptoms of anxiety and depression in older people. However, two small studies on walking in gardens indicate that garden visits may have mental health benefits.

Given the diversity of NAT interventions and health conditions studied, it is difficult to adequately assess its effectiveness. However, some reviews suggest that NAT may assist to improve quality of life and general wellbeing.

Considerations

Many residential and community care programs for people with dementia have included gardening as a component. Both gardening and NAT may need to be tailored to meet individuals' needs, particularly where they have physical limitations or allergies. Physical assistance and modifications, such as raised garden beds, may be necessary. Adequate seating and enough space for wheelchairs will also be required. If access to outdoors is difficult, gardening can be undertaken with potted plants, which can be moved around easily. Costs associated with a gardening program may be a challenge to implementation.

No training is required to implement a gardening intervention, but gardening knowledge and skills are required.

Recommendation

Gardening, garden visits and NAT are safe and inexpensive ways of improving mood and emotional wellbeing in older people and may improve symptoms of depression.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Balranald Hostel is a low-care 15-bed hostel, in a small, isolated rural community situated in south-west NSW near the Victorian border. Saltbush Yarns is a gardening project established to address the needs of the residents, most of whom have a farming background. The Balranald Shire supplied the initial labour and machinery needed to set up the outdoor areas, and volunteers gave practical support.

The communal garden space is a safe and secure environment with raised garden beds where seasonal vegetables are grown, fruit trees, a chicken coop and chickens. Residents also make their own fly traps. Seating is provided. Residents are involved in planting, weeding, and picking and preparing the home-grown produce, as well as looking after the hens and collecting the eggs. The garden provides an outdoor space for residents to interact in a safe environment.

Staff members have observed improvements in overall wellbeing, in particular a decrease in symptoms of depression. Residents use the garden space to exchange stories, ideas and knowledge, and have noted they feel more accepted and have an increased sense of self-worth and community connectedness.

Case study

A group of older men and women who attended an activity group in an urban area expressed an interest in contributing to greening the environment. The activity group coordinator found out about the Tree Project, in which volunteers plant seeds and raise tree seedlings for distribution to rural areas. The emotional wellbeing of group participants was enhanced as they felt they were being productive as well as making a valued contribution to the environment.

Laughter therapy and laughter yoga

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	?	?

What is it?

Laughter therapy and laughter yoga involve various techniques that aim to make participants laugh. Laughter is seen as a kind of exercise that is fun to do but does not rely on humour, jokes or comedy. Laughter yoga combines laughter with breathing exercises. Laughter might be stimulated by:

- chanting ho-ho-ho, ha-ha-ha, or he-he-he
- pronouncing a nonsensical word or sounds, such as Ah-E-I-Oh-Woo.

How is it meant to work?

Laughter is thought to relax the whole body, boost the immune system, and relieve physical tension and stress. Laughter triggers the release of endorphins, the body's natural feel-good chemicals. Endorphins promote an overall sense of well-being and can even temporarily relieve pain.

Does it work?

We do not have enough evidence to know if laughter therapy is an effective intervention for anxiety and depression in older people. However, the results from one good quality study indicate that laughter therapy may be a useful, cost-effective and easily accessible intervention that has positive effects on depression, insomnia, and sleep quality in older people. Another study conducted in Iran with depressed older women found that laughter yoga is at least as effective as group exercise in improving depression and life satisfaction. Laughter yoga is being trialled in some residential care facilities in Melbourne (see case study opposite).

Considerations

Laughter therapy and laughter yoga may have different results depending on how well people are engaged in the activity. Laughter therapy and laughter yoga sessions should preferably be conducted by people with some training, but the techniques are easily learned and incorporated into other exercise interventions.

Recommendation

While we do not yet know whether laughter therapy is an effective intervention for anxiety and depression, it may be useful to relieve tension and foster positive emotions.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The laughter yoga program is a group activity that was conducted by a trained laughter yoga therapist in a group of residential care facilities in Melbourne for six weeks. Sessions were around 30 minutes long. About 10 people regularly participated, some with mild cognitive impairment. Participants were guided through simulated laughter exercises, all of which naturally prompt laughing, such as the 'greeting laugh' where people shake hands whilst laughing, or the 'tapping the body awake' laugh, where participants gently tap their arms and legs whilst simultaneously laughing. The residents preferred to be in a closed environment where they could not be observed by people outside the group.

Laughter yoga sessions were well attended and enjoyed by both residents and staff. After several months of laughter yoga sessions, data were collected and the results have been overwhelmingly positive, with improved mood and higher happiness scores after the class and slight decreases in blood pressure. The laughter therapist said meeting as a group also increased residents' sense of community and could foster friendships and social engagement. Comments from staff have been positive about the laughter yoga spin-offs: One relative commented on how she noticed her mother smiling for the first time in ages and told staff, "Whatever you are doing, keep it up!"

Tai chi and qigong

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	?
Depression	👍👍👍	?

What is it?

Tai chi is a type of moving meditation that originated in China as a martial art. It involves slow purposeful movements and focused breathing and attention. Qigong is a 3,000-year-old Chinese self-training method involving meditation, breathing exercises and body movements.

How is it meant to work?

In traditional Chinese medicine, tai chi is thought to benefit health through the effects of particular hand and foot movements on important acupuncture points and body channels. Tai chi could also help depression because it is a type of moderate exercise, or because it is a relaxing distraction from anxiety and stress.

The traditional Chinese explanation for how qigong works is that it regulates the flow of qi (energy) throughout the body. It removes imbalances or blockages which cause emotional problems or physical symptoms. A scientific explanation is that qigong reduces the body's release of the stress hormone cortisol.

Does it work?

Evidence from a review showed that the use of tai chi in older people is associated with significant improvement in physical function and reduced blood pressure and risk of falls. The studies focusing on depression had varying results, but two studies of moderate quality showed fewer symptoms of depression. Another study showed a decrease in anxiety for a tai chi group, but these were similar to a standard exercise group.

Evidence from two studies suggests that qigong could be beneficial for depression. We do not have enough evidence to know whether qigong reduces symptoms of anxiety.

Considerations

Older people's physical capacities will need to be assessed before implementation. The intensity and frequency of tai chi may have varying outcomes for older people. Ideally, tai chi and qigong should be practiced over a long period of time. Where people have difficulty with balance, tai chi can be undertaken seated.

Tai chi and qigong sessions should be conducted by trained instructors.

Recommendation

Tai chi and qigong are safe and cost-effective activities that may improve both physical and psychological functioning of older people.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The tai chi program in residential apartments for older people began as a trial and is conducted by a volunteer. The volunteer had previous experience working in aged care and had participated in an education course to teach and conduct tai chi classes through her employment. The volunteer was approached by the organisation to provide tai chi classes for the residents and it has become a great weekly activity. The class was demonstrated at an open day and many residents were encouraged to try it. On average 6–10 residents participate and the class is tailored according to their capability, so some residents are seated throughout the class. The activity has become a regular social gathering, and the volunteer and residents enjoy morning tea and conversation after the class.

Tai chi has been a way of introducing some regular movement and exercise, which residents say is beneficial. The class is conducted in a very light-hearted manner with plenty of interaction and laughing, which promotes wellbeing. The classes have been continued at the request of the residents, in response to their feedback.

Yoga

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	?
Depression	👍👍👍	👍👍👍

What is it?

Yoga is an ancient part of Indian culture. Most yoga practiced in Western countries is Hatha yoga. This type of yoga exercises the body and mind using physical postures, breathing techniques and meditation.

How is it meant to work?

Yoga is thought to reduce stress and improve relaxation. It may also increase feelings of mastery from learning difficult postures or improve body image from greater body awareness and control. It may also help to distract people from negative thoughts.

Does it work?

Yoga programs in community and residential settings resulted in improved physical and mental health. The authors of one study suggested that yoga might be more beneficial in the early stages of dementia than in later stages.

Results from a review of several studies with a focus on anxiety suggest that yoga can reduce anxiety in certain situations. This review did not have a focus on older people, but some of the studies included older women with breast cancer.

Another study involved older people who practiced Iyengar yoga. When asked about the benefits of yoga, they listed improved gait and balance, decreased pain, decreased need for medications and decreased stress, improved sleep, less anxiety and depression, increased mobility, increased self-awareness, and a greater sense of peace.

Considerations

While yoga is usually practised on a mat, it can be modified to suit the needs of frail older people (e.g. chair yoga). Training is required to lead a yoga class.

Recommendation

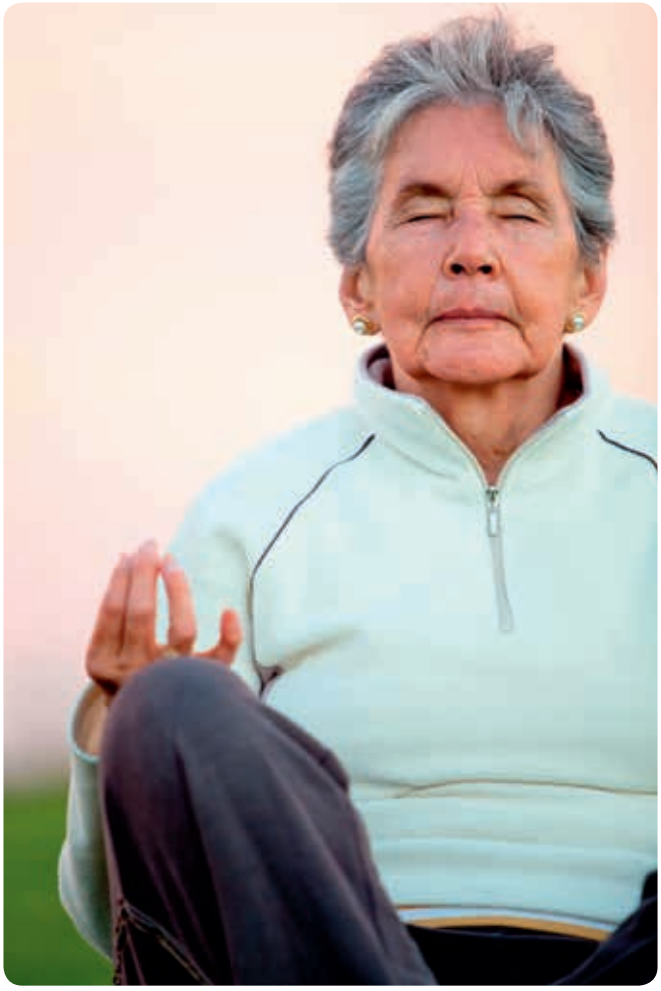
Yoga appears to be a suitable intervention to improve emotional wellbeing and physical health, mobility and balance.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

One exercise therapist working in residential care relies on a DVD featuring chair yoga exercises especially designed for older people. The DVD demonstrates a range of simple, gentle exercises for all the major joints in the body, covering arms, legs, neck, back, and eyes. Breathing training and deep relaxation are also included, and the slow, meditative pace of the DVD helps motivate the older people to attend sessions regularly.

The therapist said, "I have been using this DVD with a group with various disabilities. We do half to one hour twice a week. People come because they know they will leave relaxed and loosened. One person uses a wheelchair and oxygen tank and has noticed how much easier it is for her to breathe after doing some of these stretching and breathing exercises. They expand the lungs and teach the person how to utilise their whole body for breath. Another person has low mobilisation and the gentle stretching and rotations help facilitate movement in her joints and lower muscle pain. When the class is over, everyone is smiling, commenting on how good they feel and how relaxed they are."



Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Relaxation

Humour therapy

	Community settings	Residential care settings
Emotional wellbeing	?	👍 👍 👍
Anxiety	?	?
Depression	?	?

What is it?

Humour therapy involves using humour to facilitate laughter and happiness. The humour can be delivered by an individual (such as a clown) or recorded (for example a video), or participants can be shown how to generate humour themselves.

How is it meant to work?

Humour therapy is thought to increase problem solving and memory efficiency, and facilitate social communication, social influence and bonding, tension relief, and coping with anxiety.

Does it work?

We do not have enough good quality studies to know if humour therapy decreases symptoms of anxiety and depression.

One study found that humour therapy did not impact the level or severity of depression but did reduce agitation. It had a similar effect to risperidone, the most commonly used antipsychotic medication in Australia for the treatment of behavioural disturbance in dementia.

Considerations

Humour therapy is generally considered a safe intervention and might be a suitable alternative before using medication. Formal humour and laughter therapy require some training to deliver effectively, but any staff member can enjoy laughter with clients or residents.

Recommendation

We do not know if humour therapy is an effective intervention for anxiety and depression. However, it might be useful to reduce agitation in people with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Elder Clowns™ are highly skilled professional performers trained by The Humour Foundation to work in aged care and dementia facilities. Elder Clowns™ aim to improve quality of life by working in partnership with facility staff and residents, using the healing power of humour to increase a residents' personal wellbeing, enhance their self-image and maintain positive interactions with others.

A family member wrote a letter saying, "I wanted to be able to thank you so much for allowing our aged care facility to take part in your wonderful program. You have been visiting with my darling mum Louise. It has been such a wonderful program and a joy to see the smiles on all those residents lucky enough to have taken part. ... We are very fortunate to still have mum who is 96 this year and that most of all she still has her wonderful sense of humour. ... I truly believe that mum is far more involved with our conversations and in particular have noticed that she is interacting and making comments with me and my three year old grandson. ... I find also that she is not sleeping as much during the day."

Massage

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	👍👍👍
Depression	?	?

What is it?

Massage involves the manipulation of soft body tissues using hands or a mechanical device. Massage is often provided by a trained professional. One of the aims of massage is to relieve tension in the body.

How is it meant to work?

This is not known. However, it is possible that massage reduces stress hormones or reduces the body's physiological arousal.

Does it work?

A review combining the results of 21 studies found that slow stroke back massage reduces psychological stress. Studies on hand massage showed a consistent reduction in verbal aggression and non-aggressive behaviours in people with dementia. A minimum of three minutes of slow stroke back massage or 10 minutes of hand massage is needed for massage to be effective.

Considerations

Staff should wash their hands before and after giving a hand massage. Staff should proceed with care if the client or patient has thin, dry skin, impaired range of motion, or fragile bones. Even gentle hand massage may not be appropriate if the person has bruises or cuts, severe pain, excess fluid, or inflammation.

Massage can be used easily by formal and informal caregivers with some preparation. However, formally trained massage therapists may be most effective.

Recommendation

Slow-stroke back massage and hand or foot massage promote relaxation in older people across all settings and may reduce symptoms of anxiety.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Mary was 81 years old and had been living in a nursing home for seven months. Mary had diagnoses of Alzheimer's disease, anxiety, insomnia, osteoarthritis and osteoporosis, and had recurring urinary tract infections. She had fallen several times and needed a wheelchair to get about. She had increasing difficulty communicating her needs and had recently begun to yell out and, at times, bang on her wheelchair. She attended group activities, but the yelling and banging upset others and she was often removed from the group. She spent much of her time in her room.

The personal care attendants and activities staff offered hand massages three times per day. Each session took five to 10 minutes, typically after breakfast, before group activities and in the evening. Mary liked the idea of having lotion applied to her hands and responded to the one-to-one attention. After one week, the activity director reported that Mary was able to remain in more group activities without disruptive yelling and only occasional banging on her wheelchair. The care staff reported that Mary was less restless at night. The overall impact of implementing hand massage was an increase in quality of life for Mary and decreased job stress for staff.

Meditation

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	👍👍👍
Depression	👍👍👍	?

What is it?

There are many different types of meditation, all of which train people to focus their attention and awareness. Some types of meditation involve focusing attention on a silently repeated word (a mantra) or on the breath. An example is transcendental meditation. Others involve observing thoughts without judgment. An example is mindfulness meditation, or vipassana. Although meditation is often practised for spiritual or religious reasons, it can also be used as a non-religious technique. Some meditation methods have been used within Western psychological treatments. An example is mindfulness-based stress reduction (see page 117).

How is it meant to work?

Meditation may reduce anxiety and promote relaxation. Also, mindfulness meditation might help a person to distance themselves from negative thoughts. The focus of mindfulness meditation is to train the brain to stay in the moment. To do this, people are taught to let go of the regrets of the past as well as anxieties about the future. With diseases like breast cancer, meditation is designed to help deal with the stress that comes with the disease.

Does it work?

Meditation techniques appear to be beneficial for reducing anxiety and stress, but very few studies have been carried out with older participants. A recent high-quality review of the use of meditation techniques in all age groups concluded that meditation can result in small-to-moderate reductions of several measures of psychological stress, including anxiety and depression.

Considerations

Approximately 30 minutes of daily meditation are required to sustain the benefits of meditation. Meditation may conflict with the older person's personal belief systems, despite its potential benefits. In very rare cases, meditation can make people feel anxious or trigger loss of contact with reality, so caution is needed in people who have had a serious mental health disorder. Simple meditation techniques have been taught to people with mild memory impairments. Training is readily available for people who wish to teach meditation.

Recommendation

Meditation appears to be helpful for older people and their caregivers in reducing stress and anxiety, but the evidence is not very strong.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

A regular meditation group was organised for residents with mild or no cognitive impairment. Many of the residents who participated were widows or widowers, aged over 80, who experienced symptoms of depression and agitation. Other participants were newer residents who were experiencing difficulty adjusting to life in residential care.

The meditation group was conducted on a regular basis to enable residents to relax in a supportive environment. It was noted that the meditation group was more successful when conducted in the morning as residents were often more tired in the afternoon.

The meditation group produced both short-term and long-term effects for the residents who participated. Short-terms effects such as smiling and a feeling of relaxation were noted by the diversional therapist. Long-term effects, such as a reduction in symptoms of anxiety and depression, were noted by the doctor and nursing staff. The residents who participated said that they enjoyed the meditation group and looked forward to participating.

Reiki

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	👍👍👍	?
Depression	👍👍👍	?

What is it?

Reiki (pronounced 'ray-key') is a form of energy healing that originated in Japan. A session of reiki involves a practitioner lightly laying their hands or placing them a few centimetres away from parts of the person's body for three to five minutes per position. With distance reiki, the practitioner works without being physically present with the other person.

How is it meant to work?

There is no scientific explanation for how reiki works. Practitioners believe reiki uses life force energy present in all living beings to promote self-healing. This energy is believed to flow through the practitioner's hands to the recipient of reiki.

Does it work?

Three small studies found reiki beneficial for pain, anxiety and depression. More evidence is required to be confident about its effectiveness.

Considerations

Reiki can be individualised to meet the needs of the client. Reiki classes should be undertaken only by trained masters.

Recommendation

Older adults who experience pain, anxiety or depression may benefit from reiki.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Relaxation training

	Community settings	Residential care settings
Emotional wellbeing		
Anxiety		
Depression		

What is it?

There are several types of relaxation training. The most common one is progressive muscle relaxation. This teaches a person to relax by tensing and relaxing specific groups of muscles. Another type of relaxation training involves thinking of relaxing scenes or places. Relaxation training can be learned from a professional or done as self-help. Recorded instructions are available for free on the internet. They can also be bought on CDs.

How is it meant to work?

Relaxation training is used as a treatment for anxiety. Because anxiety can lead to depression, it may reduce depression as well.

Does it work?

Anxiety

A review looking at the results of several studies found that relaxation training can significantly reduce anxiety symptoms in adult populations. While some studies included some older people, the majority had a focus on younger adults. More research is needed to establish the effectiveness of relaxation on older adults. Relaxation techniques may not be as effective for people who also have other chronic illnesses. Applied relaxation and progressive relaxation and meditation are more effective than other types of relaxation techniques in reducing symptoms of anxiety.

Depression

A review of several studies including people of all ages found that relaxation techniques are more effective at reducing symptoms of depression than no or minimal treatment; however, they were not as effective as psychological treatment.

Considerations

A variety of relaxation techniques can be practiced by staff using simple aids such as relaxation tapes, which can be downloaded from the internet. Training is also readily available for people who wish to become relaxation therapists.

Recommendation

Relaxation may be useful for older people to relieve symptoms of anxiety and depression. However, other interventions may be more effective.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Sensory stimulation

Aromatherapy

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	👍👍👍
Depression	?	👍👍👍

What is it?

Aromatherapy is the use of essential oils, which are either absorbed through the skin or inhaled. Essential oils are volatile liquids usually derived from plants and are not oils in the strict sense. They are often prepared by fragrance extraction methods such as distillation and cold pressing.

How is it meant to work?

It is believed that the inhalation of essential oils stimulates the part of the brain connected to smell that controls emotions and retrieves learned memories. This causes chemicals to be released which make the person feel relaxed, calm, or even stimulated.

Does it work?

Three studies have shown that aromatherapy may reduce agitation in people with severe dementia and lengthen the time people spend in constructive activities. Aromatherapy may be particularly effective when combined with massage. Aromatherapy has also been tried with hospice patients, where it had a slight impact on anxiety.

Considerations

Aromatherapy should be used with caution, especially with older adults who have chronic medical conditions. Some individuals may be sensitive or allergic to these products when they come in contact with the skin or when inhaled, particularly patients who have pulmonary disease. Aromatherapy should be undertaken or supervised by people with formal training.

Recommendation

There is little evidence that aromatherapy is effective in reducing depression in older people. However, it may help with anxiety or reduce agitation in people with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

While working at a Bupa residential aged care home in Thomastown, Victoria, a staff member who was trained in aromatherapy noticed a lot of uneaten food returning to the kitchen after lunchtimes. She was inspired to introduce a sensory towels program, using sweet orange oil to improve residents' appetite. Bupa Thomastown began this initiative with eight residents, all with low appetite and declining health. They were weighed weekly and monitored daily using progress notes. During the first month, those who had been losing weight began to maintain their weight, and the others gained weight. Eighteen months later, 39 out of 45 residents are requesting a sensory towel at lunchtime.

Bright light therapy

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	?
Depression	?	👍👍👍

What is it?

Bright light therapy consists of exposure to daylight or to specific wavelengths of light using lamps or very bright lights. The light is administered for a prescribed amount of time and, in some cases, at a specific time of day.

How is it meant to work?

Older people, particularly those living in residential care, may experience very little natural light and chronic light deprivation. The effectiveness of light therapy for treating some kinds of depression may be linked to the fact that light therapy makes up for lost sunlight exposure and resets the body's internal clock.

Does it work?

A small number of studies on the use of bright light therapy in residential care settings (one conducted with older people living with dementia) have demonstrated modest benefits of bright light.

Considerations

Ultraviolet light can damage skin and is a factor in the formation of cataracts, so should be used cautiously. Bright light should not be combined with some medications or herbs (such as St. John's wort) that increase skin sensitivity to light. The dosages of light required to have a positive effect are not known.

Bright light therapy should be used only by people with some training. However, many residents or clients will enjoy short periods of mild sunshine when weather conditions are suitable.

Recommendation

Some evidence supports the use of bright light therapy in older people living in residential care, including those with dementia. Most studies have shown no serious side-effects of bright light therapy. However, it should be used with some caution with older people on medications that increase their sensitivity to light.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Snoezelen

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	👍👍👍
Depression	?	👍👍👍

What is it?

Snoezelen, or multi-sensory stimulation (MSS), is a widely used and accepted approach with residents with dementia. Developed in the Netherlands, it can be defined as an approach that actively but gently stimulates the senses using light, sound, smell, and taste. The term snoezelen is a contraction of the Dutch verbs "snuffelen" (to seek out or explore) and "doezelen" (to relax).

A variety of activities can be undertaken in a multi-sensory room, such as reminiscence, physiotherapy, and complementary therapies.

How is it meant to work?

The goal of snoezelen is to provide the client with a pleasurable experience and sense of wellbeing. It is unclear how snoezelen works and we need to gain more insight into the underlying mechanisms.

Does it work?

Snoezelen has not yet been properly evaluated in well-designed studies. However, one encouraging study in a residential dementia care setting showed that snoezelen had a positive impact on residents' behaviour and mood. Residents who received a snoezel approach, integrated into 24-hour daily care, showed less apathy, loss of decorum, rebellious and aggressive behaviour, and depression than the control group who received usual care. During morning care, residents receiving the snoezel program were happier and more responsive than the control group.

Considerations

The application of snoezelen requires appropriate knowledge and skills and should be tailored to the client or resident's personal circumstances, including their lifestyle, preferences, desires, and cultural background. Training toolkits are available online. Alzheimer's Australia Tasmania has set up a mobile snoezelen room that can provide sensory therapy in any location.

Recommendation

While there is not much scientific evidence on whether snoezelen is an effective intervention for anxiety and depression, it may be a useful tool in residential care settings to relieve tension and foster positive mood.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**


Alzheimer's Australia
TASMANIA
MOBILE SNOEZEL ROOM
Alzheimer's Australia
MOBILE SNOEZEL ROOM
KT 3451

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Music and arts

Art therapy and craft

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	👍👍👍	👍👍👍

What is it?

Art therapy is a form of treatment that encourages people to express their feelings using art materials, such as paints, chalk or pencils. In art therapy, the person works with a therapist, who combines other techniques with drawing, painting or other types of art work, and often focuses on the emotional qualities of the different art materials.

Craft groups, based around activities such as knitting, needlecraft or other handicrafts, can provide a supportive setting for social contact and enjoyment.

How is it meant to work?

Art therapy is based on the belief that the process of making a work of art can be healing. Issues that come up during art therapy are used to help the person cope better with stress, work through traumatic experiences, improve his/her decisions, and have better relationships with family members and friends, thereby increasing the person's quality of life.

Craft groups are less structured than art therapy and rely on social contact and the sense of achievement that comes through using well-learnt skills to make something attractive or useful.

Does it work?

Art therapy and craft groups have not been properly evaluated in well-designed studies, and most reports are case studies. However, the limited evidence available indicates that arts and craft may be beneficial and appropriate interventions for older people with depression and potentially useful for those with dementia.

Considerations

Art therapy programs should be delivered by qualified art therapists. However, craft groups may be run by anyone with an interest in craft and some knowledge and skills.

Recommendation

We do not yet know if art therapy or craft work for anxiety. They may be effective for reducing symptoms of depression and improving wellbeing.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The Knitting Room began as a small project at Rosetta Community residential care home in Tasmania in 2003, under the guidance of an artist. The aim was to recreate part of a 1950s room, with everything life-sized, using only the traditional skills of knitting and crochet. About 50 residents, family and friends created individual and group pieces that contributed to the overall display. The first public exhibition of The Knitting Room in August 2004 was well received, and the project was expanded with greater community involvement.

Successful grant applications to the Australia Council Community Development Fund, Tasmanian Regional Arts and the Glenorchy City Council, provided extra funds during 2005/06 to expand the project. Three artists were employed part-time to assist in providing free, weekly public workshops at Rosetta Community. Another 24 formal workshops were also conducted at six regional centres.

Over 400 Tasmanians, including many nursing home residents, have now combined their talents and memories to create this exhibition. The film crew of the popular television show *The Collectors*, recorded a segment about The Knitting Room, and this was broadcast nationally in early 2007. The program aptly described the Knitting Room as a collection of memories, recreated as three-dimensional objects and settings.

Case study

Amana Living residents at Wearne House in Mandurah, Western Australia, took part in an art therapy exhibition aimed at helping those living with dementia. About 20 residents, some with dementia, produced artwork for the third annual Project Picasso Exhibition. The artworks were produced over a six-week period with the help and support of staff and volunteers.

An occupational therapy assistant said the project had been a success. "We had one resident do 11 different pieces and a lady in her 90s did some really lovely work," she said. "It wasn't just based on painting: we tried to use things that we didn't have to spend money on, things like old jigsaw pieces and buttons. One of the pieces we've decided to keep and to frame for our hallway."

The Amana Living dementia and restorative services manager said the artworks were fascinating and often surprising. "We have been blown away by the talent that our residents and clients living with dementia have displayed," she said.

Dance and movement

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	👍👍👍	👍👍👍

What is it?

Dance and movement therapy (DMT) combines expressive dancing with more usual psychological therapy approaches to depression, such as discussion of a person's life difficulties. A DMT session usually involves a warm-up and a period of expressive dancing or movement. This is followed by discussion of the client's feelings and thoughts about the experience and how it relates to their life situation.

More informally, dancing may also be used as a fun activity or opportunity for social interaction.

How is it meant to work?

DMT is based on the idea that the body and mind interact. It is thought that a change in the way someone moves will have an effect on their patterns of feeling and thinking. It is also assumed that dancing and movement may help to improve the relationship between the person and the therapist, and may help the person to express feelings. Learning to move in new ways may help people to discover new ways of expressing themselves and to solve problems.

Does it work?

A review of studies related to dancing interventions for older people with dementia living in residential care found that a wide range of approaches had been tried, including therapeutic dance, dance movement therapy, social dancing and dance-based exercise. The review showed that problematic behaviours decreased, and social interaction and enjoyment in both residents and care staff improved. Two small studies found that symptoms of depression improved.

Considerations

Physical limitations and music preferences need to be taken into consideration. Dance may be a useful activity for people with dementia.

No special skills are required to enjoy dancing with clients or residents. However, formal dance and movement therapy requires a trained therapist.

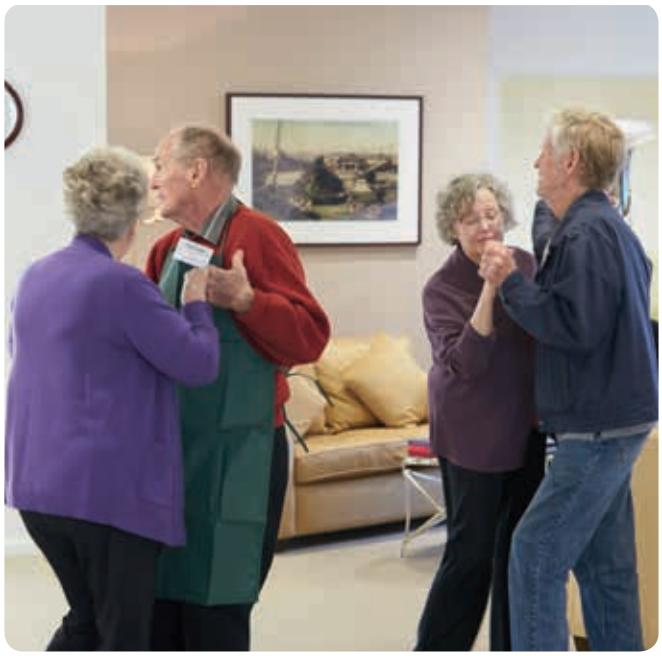
Recommendation

Dance appears to have positive effects on symptoms of depression in older people, at least in the short term.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

A dance and movement program in residential care was designed to encourage residents to participate in physical activity in order to improve mobility and balance as well as to provide an opportunity for reminiscing, reduce social isolation and encourage movement and creativity in a non-judgmental environment. The dance and movement program is tailored to meet the needs of the participants. Residents participate on a regular basis and staff members have noted an improvement in symptoms of depression.



Case study

A Dementia Behavioural Management Advisory Service (DBMAS) in Perth introduced a particular form of dance, called Wu Tao dance, to people with dementia living in a residential care facility. Wu Tao, invented in Western Australia, uses music, meditation and dance therapy with people with restricted movement or cognitive difficulties. Wu Tao involves both movement and stillness.

A therapy room was established in the facility, which was quiet, relaxing and spacious enough to allow movement. Chairs surrounded the dance area, enabling residents to sit down during the session if they wished. It was important to include a midway break in the dance session, which gave residents and the instructor the opportunity for refreshments.

In February 2009, six residents from a low-care facility, five women and a man aged between 81 and 92, were identified with symptoms of agitation and invited to join the dance sessions. Assessors also took part so they could assess visual non-verbal cues during the dance. For example, smiling and interaction with staff members was noticed, and residents who usually had disagreements tended to group and bond together. Changes were monitored via follow-up phone calls each week to the facility.

All participants in the dance group, which included residents and staff, indicated that Wu Tao was a pleasurable and enjoyable therapy.

Music and singing

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	👍👍👍
Depression	👍👍👍	👍👍👍

What is it?

In music therapy a therapist uses music to help someone dealing with stress, anxiety and/or depression to overcome his or her problems and enhance wellbeing and quality of life. Music therapy is often combined with another approach to psychological therapy, such as cognitive behaviour therapy (see page 112).

Different approaches to music therapy can include people playing and making their own music, or just listening to music. Some programs use familiar or favourite music and songs to enhance reminiscence, while others use new music. Many programs combine music with group singing. Choirs of older people have been successfully established.

How is it meant to work?

Music appears to affect brain systems that control emotions. This emotional effect could be due to the rhythm and melody of the music or to the personal meaning the music has for the individual.

Sometimes people are asked to perform another activity while listening to music, such as relaxation, meditation, movement, drawing or reminiscing. Making one's own music is thought to help by allowing the person to experience a good relationship with their therapist through making music together, and to explore new ways of expressing oneself (similar to art therapy).

Does it work?

Music therapy and singing have been found to improve psychosocial wellbeing in a variety of settings. These interventions are also helpful in alleviating symptoms of anxiety and depression and improving quality of life.

Considerations

Careful assessment of the importance of music and preferences of older adults is required before implementation. Group music activities are appropriate for people with mild to moderate dementia. Music is able to reduce problem behaviours, such as agitation and wandering, among older residents living with dementia, and may be useful at mealtimes.

While music and singing may be used informally by any staff with an interest, some knowledge and skills in music would be helpful. Formal music therapy requires a trained music therapist.

Recommendation

Music therapy appears to be helpful in alleviating symptoms of stress, anxiety and depression in older adults. Singing and listening to music can be incorporated into caring for people living with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

A singing and song writing program was developed in a residential care setting as part of an ongoing music therapy program for older adults with dementia who also experienced symptoms of depression. Song writing enabled the group to explore and express emotions as well as assist with memory, cognitive and language skills. The group collaborated, writing songs that held significant meaning to each of the individuals within the group. Singing enabled the group to share their journey with others, giving them a sense of achievement. Overall, the program provided many benefits to the group by enhancing their emotional, psychological, physical and social wellbeing, which was noted by the staff, family members and other residents.

Case study

ACH Group in South Australia has established choirs in community settings, and people living in residential care can also attend with the support of their families. Most of the participants were living at home and isolated. They were interested in singing or music but few had significant musical knowledge.

Each group has 25–30 singers. The choir spends two hours each week learning new songs and new arrangements of older songs, with professional choir leaders. Each session includes a physical warm-up and afternoon tea. While a standard was set, it was done with encouragement, taking small steps at a time, and involving a lot of fun, laughing and singing for pleasure. The groups build up to local performances and an annual performance at the Adelaide Festival Centre.

Choir leaders were provided with training in working with people with dementia and those who are frail. Staff and volunteers are involved in the choirs as singers and support buddies where needed.

Quality of life surveys before and after eight months of rehearsals and focus group discussions were used to gather data on the choirs. Singers reported improvement in breathing, energy, mood and sense of purpose along with improved singing and confidence. They had something to look forward to and reported that they felt more energetic. Formal evaluation of choirs also indicated improved mood. Producing a DVD of the performance and a promotional DVD was important for the singers.

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Social activities

Animals and pet therapy

	Community settings	Residential care settings
Emotional wellbeing	👍 👍 👍	👍 👍 👍
Anxiety	?	?
Depression	?	👍 👍 👍

What is it?

Animals and pet therapy is a group of treatments where animals are used by a trained mental health professional. Usually these animals are pets such as dogs and cats, but other animals such as horses can also be used. The interaction between the client and the animal is a focus of the treatment and is thought to have benefits for the person's wellbeing.

Animals can also be used in less structured ways to provide companionship in residential care settings. The animal usually has a calming influence on the resident and provides positive reinforcement through purring or wagging a tail when spoken to or touched. The presence of the animal may provide a topic for conversation with other residents.

How is it meant to work?

It has been claimed that interacting with animals has physiological benefits, both through increased levels of activity and the beneficial effects of being around animals. It is also believed that interacting with and caring for animals can have psychological benefits by improving confidence and an increased sense of acceptance and empathy.

Does it work?

Two good-quality studies have shown that animal-assisted interventions can have a positive impact on symptoms of depression in residential care settings. A review of studies found a positive influence on people with dementia by reducing agitation and by improving the extent and quality of their social interactions.

Considerations

Some people may fear dogs or be allergic to pet hair. There is a small possibility of contagious disease transmission, a possibility of bites or scratches, and a possibility of clients mistreating animals. Owning a pet requires a level of responsibility, and also unexpected costs such as vets' bills may become an issue.

Introducing pets into an aged care setting may by trialled by any staff member with some skills and knowledge. If dogs are to be used, training in dog handling may be useful.

Recommendation

The use of pets has been shown to reduce symptoms of stress and depression. It may be useful to improve overall health and wellbeing outcomes for people living in long-term care settings, including those with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The largest animal-assisted therapy association in Australia, the Delta Society is a national not-for-profit organisation whose mission is to promote and facilitate positive interaction between people and companion animals. Volunteers and their accredited companion animals visit a range of health care facilities, including residential aged care.

The Delta Society says that, "Delta Therapy dog teams have encouraged residents to leave the confines of their rooms for the first time in months, to extend their hand post-stroke or surgery, to walk, to talk, to smile, to laugh, to remember, to forget, and to reminisce about their own animals."

Buddying and befriending

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	👍👍👍	?

What is it?

Buddying or befriending is a way of providing social support. It involves a relationship between two or more individuals that is initiated, supported and monitored by an agency. It ideally requires commitment over time.

How is it meant to work?

Befriending provides the client with additional social support through the development of an affirming, emotion-focused relationship over time.

Does it work?

There is very little evidence on the effectiveness of befriending programs for older people. In general, befriending seems to have some effect on reducing symptoms of depression.

Considerations

Careful assessment of the older person is required before starting a befriending or buddying intervention. No special training is required to implement buddying or befriending programs, though skills in diversional therapy, occupation therapy or social work would be helpful.

Recommendation

Buddying and befriending are low-cost interventions that can make the most of available volunteers. They may improve quality of life and reduce symptoms of depression.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The Australian Government's Community Visitors Scheme (CVS) is a national program that provides companionship to socially isolated people living in government-funded aged care homes. A variety of community-based organisations recruit, train and support volunteers, match volunteers to residents. Judy was matched with Ivy through Red Cross.

In 1994, Ivy was living at the Tweed Heads Nursing Centre in northern New South Wales, paralysed from the waist down and receiving morphine through a pump to relieve extreme pain. Senior staff asked for a special community visitor for Ivy: someone caring and sensitive to visit and support her through this difficult time. Judy accepted the invitation to visit Ivy. Judy was not expecting theirs would be a long friendship, but 20 years later, their relationship is stronger and more special than anyone could have foreseen.

"I was asked to visit with Ivy 20 years ago and I still visit her most weeks," says Judy. "It is wonderful for me, as Ivy has become part of my life. Ivy was 64 when I first met her. She couldn't move and was in pain but she always had a smile on her face. Christmas is always a fun time for us as I decorate Ivy's room and she invites me to the nursing home party. Ivy is still in pain and less cheerful now and the visits have become harder, and I don't stay as long. Ivy is now profoundly deaf and it is exhausting for us both to try to talk. We are able to sit and be together. I hold her hand and being there is enough."

Intergenerational programs

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	?	?

What is it?

Intergenerational programs bring children, young people and older adults together. The focus is usually on establishing connections between people who are 21 years of age and younger, and people who are 60 years of age or older, with the intention of benefiting one or both age groups.

How is it meant to work?

Intergenerational programs are thought to facilitate the sharing of talents and resources. The aim is for program participants to interact, stimulate, educate, support and provide care for one another.

These efforts to facilitate meaningful intergenerational engagement can enhance the quality of people's lives and strengthen communities.

Does it work?

Although intergenerational programs are widespread, not enough well-designed studies have been carried out to tell us whether intergenerational programs improve symptoms of anxiety and depression in older people. Anecdotal evidence suggests that they are popular and well-liked by participants.

Considerations

Cultural background and views about ageing and intergenerational relationships need to be considered when matching people of different generations. No special training is required to implement intergenerational programs, though skills in diversional therapy, occupation therapy or social work would be helpful.

Recommendation

We do not yet know if intergenerational programs alleviate symptoms of anxiety and depression. However, they are generally well-liked by participants and may improve quality of life.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The intergenerational program implemented by a day care service involved a partnership with a local secondary college. The purpose of the intergenerational program was to connect younger people with older people within the community who had some symptoms of depression. It provided an opportunity for older people to share their knowledge, contribute to the community in a positive and meaningful way, feel valued for their contribution, and above all to have fun. Students and older people were grouped together according to the numbers participating. Older people who participated in the program felt they could make a meaningful contribution to a different generation and to others within the community through sharing their knowledge.

At the end of the program, the students developed a presentation to showcase their learning experience. The students presented the life stories of the older people as well as tangible items created through the experience, such as a quilt. Older participants completed a survey to rate the outcomes and satisfaction from their involvement with the program. The results noted a high level of satisfaction from both the older participants and the students involved. The intergenerational program assisted both groups to feel more connected within the community by bridging the generation gap as well as developing friendships and improving social support. Teachers also commented that some students with a history of missing school had much better attendance on days when the program ran.

Men's Sheds

	Community settings	Residential care settings
Emotional wellbeing		
Anxiety		
Depression		

What is it?

A community-based Men's Shed is usually a large shed that is equipped to enable men to come together, socialise and undertake enjoyable and meaningful activities, such as woodwork and/or metalwork. Men's Sheds were conceived as places where friendships could develop and health information could be provided.

How is it meant to work?

Men's Sheds are a health promotion initiative. They are thought to counter isolation and promote health and wellbeing through engaging in meaningful activities.

Does it work?

One Australian study concluded that Men's Sheds can have a role in promoting men's health and wellbeing by supporting their engagement in activities they enjoy and find meaningful. This, in turn, provides a sense of purpose and identity. The social environment of Men's Sheds leads to the development of positive social relationships with other men and a sense of belonging.

There is anecdotal evidence that Men's Sheds may decrease symptoms of anxiety and depression in older men.

Considerations

Men's Sheds may provide a supportive environment for men with dementia or memory loss. No special training is required to set up a Men's Shed, though skills in diversional therapy, occupation therapy or social work would be helpful. For older men who can't access a physical Men's Shed, there is a virtual shed that is based on the same principles and can be accessed at www.shedonline.org.au

Recommendation

Getting involved in a Men's Shed has the potential to increase social and physical wellbeing for older men who live in the community or in residential care. Men's Sheds appear to improve emotional wellbeing and may alleviate symptoms of anxiety and depression.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Staff of a residential aged care facility recognised there was a need to address the gap in activities specifically for men. It was noted that there was a successful Men's Shed in operation within the community, therefore after discussion with stakeholders and residents, it was decided that an onsite Men's Shed would be beneficial, particularly for men with symptoms of anxiety, depression or dementia.

The Men's Shed was set up to ensure that men could gather in a safe environment, with no expectation to build or repair items. The Men's Shed primarily offered a space for men to interact. It also offered opportunities for the men to engage with the broader community. Staff noted that the Men's Shed was useful in reducing symptoms of anxiety and depression and helped manage behavioural concerns associated with dementia.

Volunteering

	Community settings	Residential care settings
Emotional wellbeing		
Anxiety		
Depression		

What is it?

Older volunteers provide a wide range of services through a variety of programs. Examples include volunteering within sports and recreation, social services such as meals-on-wheels, education, and religious organisations.

How is it meant to work?

Engaging in new roles can increase the wellbeing and health of older adults.

Does it work?

There is considerable evidence that volunteering benefits older people by increasing social participation and providing a socially valued role. Older volunteers themselves experience an increased sense of meaning. Volunteering by older people with anxiety and/or depression has not yet been properly evaluated in well-designed studies.

Considerations

Older people with anxiety or depression may need ongoing support with their volunteering activities. No special training is required to assist older people to become volunteers, though skills in diversional therapy, occupation therapy or social work would be helpful.

Recommendation

Volunteering is a valued activity that may improve older people's social participation and quality of life.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

A volunteering program, The Madagascar Project, was developed by Feros Care, as a method for residents to contribute in a meaningful way to the community. Residents were invited to a talk that focused on the needs of children living in poverty. Following this talk, residents and staff collaborated to discuss how they could use their skills to provide assistance to children living in poverty. It was agreed that hand-made products, as well as participation in community activities and fundraising events would benefit both the residents and the children living in poverty.

The residents hand-crafted a variety of products including toys and clothes, which were packed and distributed by residents. The volunteering program offered an opportunity for both men and women to participate. The program had a positive impact on the residents' social interaction and facilitated a deeper sense of compassion and understanding between residents and the needs of people within the community.

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Reflection

Life review

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	👍👍👍	👍👍👍

What is it?

Reminiscence is a general term covering a range of interventions that involve thinking or telling someone about past experiences that are personally significant. Three kinds of reminiscence can be distinguished: simple reminiscence (see page 74), life review, and life review therapy (see page 115).

Life review was developed as a structured form of reminiscence in which people are helped to re-evaluate their lives and to make use of coping strategies, either in individual or group sessions. Rather than simply describing past events (as in simple reminiscence), life review focuses on the re-evaluation of life events to form a coherent life story. Typically, sessions focus on one part of their life at a time and may use reminiscence aids such as photographs, music or aromas.

How is it meant to work?

Life review is thought to help people resolve conflicts from the past and to see their lives in balance. These processes may result in feeling gratitude for one's life and reduced feelings of despair.

Does it work?

Life review can improve emotional wellbeing and reduce symptoms of depression in older people living in the community or residential care. It has been used successfully with older people living with dementia.

Considerations

Careful assessment is needed before engaging in life review. If the older person has experienced severe trauma or has symptoms of severe depression, life review should be undertaken only by trained therapists.

Recommendation

Life review is an effective treatment for depression in older people, including those living with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The Community Education Centre in Hawthorn, Victoria, has been running a Life Writing Program with participants who are all over 70 years of age and living in their own homes or a retirement village. Some have begun to experience memory loss or show early signs of dementia. Generally, people participate in the program because they enjoy writing, want to develop their writing and perhaps want to relieve their social isolation. Writers and mentors are matched on a one-to-one basis. However, there are some Telelink participants who write alone and then share their writing with others over a phone link up.

For the participants, success can be a feeling of achievement, pride in their creative work and connectedness. Many of the writers become more confident in expressing themselves and sharing their stories. The program is not for everyone and some writers pull out, but most often they just take a break due to health or family issues. Participants frequently say how much they and their family enjoy their writing and how important the program and the other writers are in their lives. The coordinator said, "The writers are a most joyous group to be involved with. Many live in regional areas and experience some degree of social isolation but through their writing they connect with others. Their story-telling is fulfilling and productive. Writing allows participants to record memories and reflections, explanations and even heal from painful events that occurred a long time ago."

Prayer and spiritual counselling

	Community settings	Residential care settings
Emotional wellbeing	?	👍 👍 👍
Anxiety	?	?
Depression	?	👍 👍 👍

What is it?

Prayer is the act or practice of praying to God, another deity or an object of worship. Spiritual counselling is supportive counselling for the client's belief and value system, to support the essence of the person and facilitate spiritual growth and closure, in particular near the end of life.

Spiritual reminiscence raises questions about meaning in life, and the person's hopes and fears for the future are addressed. The person may talk about their relationship with God or another deity, and whether they pray, meditate, or engage in other spiritual practices.

How is it meant to work?

Prayer is thought to give people a sense of comfort, being at ease and being protected, therefore decreasing anxiety and irrational fear.

Spiritual counselling is thought to foster personal growth and find answers to questions about the meaning of life. By discussing issues such as loss of a sense of purpose, people are encouraged to explore various aspects of their life and feelings, talking freely and openly in a way that is rarely possible with friends and family, to a person who neither judges nor offers advice.

Does it work?

Cross-sectional studies have shown that religious involvement and spirituality are associated with low levels of anxiety and depression, and some research has shown that addressing the spiritual needs of older patients may assist with recovery from illness. Although prayer and spiritual counselling are common in aged care, there have been few good quality studies of these interventions for anxiety and depression, and so we do not know how effective they are.

One study that explored spiritual reminiscence in palliative care concluded that spiritual reminiscence is a useful way to explore a person's sense of meaning in life. It may also be a valuable strategy for assisting people in the early stages of living with dementia to cope with the experience of dementia and to come to acceptance of their lives.

Considerations

The expertise and skills of the staff delivering the intervention will influence its effectiveness. People's religious and spiritual beliefs should be taken into account. Pastoral care staff and chaplains are best-qualified to deliver spiritual counselling, but sharing prayer with an older person or enjoying religious music and songs may be provided by any staff member with an interest and some knowledge.

Recommendation

There is very little formal research evidence to support the use of prayer and spiritual counselling with older people, but it may be an effective intervention for people with concerns about the meaning of life or anxiety about death.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The spiritual counselling program in a residential care facility is coordinated by the chaplaincy team, which provides person-centred care and support for residents and their families. The program is conducted weekly and offers an opportunity for men and women to interact in a friendly environment to find spiritual meaning through sharing personal stories and experiences.

The spiritual counselling program has been effective in facilitating concerns about ageing, death and dying through supportive discussion and reminiscing. The program has had a positive impact on the general wellbeing of many participants and has also helped to reduce social isolation.

Case study

Members of a Victorian planned activity group talked about how difficult it was to cope with people in the group dying. They had a psychologist conduct a session with group members, staff, volunteers and carers to learn more about grief and loss and talk openly about it. They decided that each time someone died they would have a ritual. The ritual, which they planned, included sitting in a circle around a candle and photo of the person. Sometimes the carer would come and talk about what the group had meant to the person. Everyone had a chance to say something about the person who had died and a local minister gave some readings and prayers. They completed the ritual by enjoying a shared morning tea. People who wanted to talk more were provided with individual counselling or pastoral care.

Simple reminiscence

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	?
Depression	?	👍👍👍

What is it?

Reminiscence is a general term covering a range of interventions that involve thinking or telling someone about past experiences that are personally significant. Three kinds of reminiscence can be distinguished: simple reminiscence, life review (see page 70), and life review therapy (see page 115).

Simple reminiscence is unstructured autobiographical story telling with the goal of communicating with others, remembering past events, and enhancing positive feelings.

How is it meant to work?

Simple reminiscence is an enjoyable activity.

Does it work?

There is good evidence that reminiscence is effective in improving emotional wellbeing and reducing symptoms of depression in older people living in residential care.

Considerations

No particular skills are necessary to engage in simple reminiscence with older people. However, careful assessment is needed first and it should be used with caution if the older person has experienced severe trauma or has symptoms of depression. Simple reminiscence can be used effectively with people living with dementia.

Recommendation

Reminiscence is an effective approach to reducing symptoms of depression in older people.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Sybil, 100, is a resident in a Melbourne residential facility. Sybil was married to George for 70 years and following his death, her move into residential care and the onset of dementia, Sybil demonstrated obvious low mood.

Sybil's family and the staff at the aged care facility used simple reminiscence to assist with her symptoms of depression. This included Sybil's family reading letters from Sybil's husband, George sent during World War II. The letters included how much George was missing his wife and young family. Sybil listens, nods and smiles as the letters are read. A memory board was created with pictures of George and Sybil, and their family. There are pictures of George dressed in his army uniform and pictures of their family holidays. Sybil's family and the staff point out pictures from the memory board and read the captions to reinforce the significance of the pictures.

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Education and skills training

Bibliotherapy and self-help

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	👍👍👍	?

What is it?

Bibliotherapy is a form of self-help that uses books or other written material. The books provide information and homework exercises that readers work through on their own. Some of the books are based on psychological therapies, such as cognitive behaviour therapy (CBT). Self-help books can be bought and read on their own without any contact with a health professional. However, they are also sometimes used as a treatment by a therapist or GP.

How is it meant to work?

Books based on psychological therapies work in a similar way to therapy given face-to-face by a therapist. In addition, reading for pleasure may be a rewarding activity (see behaviour therapy on page 90) and can be undertaken in groups.

Does it work?

Bibliotherapy works much as other psychological interventions do for depression. A review of studies of bibliotherapy interventions for depression in older adults found that group and individual bibliotherapy are equally effective.

Considerations

The older person's level of education and literacy should be taken into account. No established guidelines currently exist regarding the use of bibliotherapy for depression. However, self-help is a form of therapy that is open to anyone, and any staff member may encourage a client or resident to read something that may be helpful.

Recommendation

Bibliotherapy is effective for depression in older adults living in the community.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Cognitive and memory skills interventions

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	👍👍👍	?
Depression	👍👍👍	?

What is it?

Educational and training approaches have been used with people who have memory loss or difficulties with cognition to teach them how to use strategies to assist in everyday life.

How is it meant to work?

Many of these interventions rely on the fact that components of memory that involve well learnt knowledge or procedures, such as playing the piano or cooking familiar recipes, remain intact for a comparatively long time in people, and even people with mild dementia can learn and retain some new information and skills. Interventions may include learning about external memory aids, strategies for learning new information and maintaining attention, and techniques for stress management.

Does it work?

A study summarising the results of 19 previous studies supported the value of cognitive interventions in improving cognitive and functional abilities for people with Alzheimer's disease. A later review supported the value of interventions for people with a mild cognitive impairment. These interventions may also be effective in reducing symptoms of depression, but there is less evidence of their impact on anxiety.

Considerations

Without careful positive support, large group situations may make some people with dementia feel anxious. They may be better helped by individual cognitive training. Professionally-led memory groups have been found to be rewarding and enjoyable for people with moderate cognitive impairment.

Formal cognitive skills training and memory groups should be undertaken only by a mental health professional. However, any staff member may encourage a client or resident to keep going with activities that provide mental stimulation and where the person is likely to succeed.

Recommendation

Studies have shown that helping people with their cognitive functioning can improve emotional wellbeing and may reduce symptoms of anxiety and depression.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Brian, 68 years old, was the treasurer for the local footy club but recently had been finding the committee meetings stressful and it was taking much longer to create the financial reports. Brian's wife, Cheryl, questioned him about it and Brian admitted that he was highly anxious about making errors, and also failing to remember the names of the committee members.

When visiting her GP, Cheryl had noticed some posters about a memory group for older people. Following some enquiries, Brian and Cheryl enrolled in a six-week group program which focused on learning about memory and memory strategies that can be easily used in everyday activities. Brian learned useful techniques and skills for managing his memory difficulties, including remembering names. He regained confidence in his own abilities, and instead of withdrawing, this allowed him to re-engage with his football club by negotiating to take another, less stressful, role on the committee.

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Interventions that rely on technology

Computer-aided therapy and computer games

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	?
Depression	👍👍👍	👍👍👍

What is it?

Computer-aided psychological therapy consists of structured sessions of therapy (usually CBT, see page 112) delivered via a computer. People work through the program on their own, rather than visiting a therapist. Examples include FearFighter, OCFighter, Anxiety online, Mindspot and Beating the blues. Computer applications, such as Flower garden, now exist for digital reminiscence therapy for people living with dementia.

Various games, recorded on disc or available online, are available for use on a home computer or via a tablet or smart phone. The games are played by manipulating a mouse, joystick, or keyboard keys in response to the graphics on the screen. The Eldergames project, sponsored by the European Union, provides cognitive training to individuals and to small groups.

There are also video games for the Wii games console that are intended to promote physical activity.

How is it meant to work?

Computer-aided psychological therapy works in a similar way as therapy provided face-to-face by a therapist.

Computer games are thought to improve cognitive function. The Eldergames project aims to improve quality of life as well as cognitive function and may be used to promote social activity. There are also games with a focus on depression. For example, Depression Quest is an interactive fiction game where the player takes on the role of someone living with depression. This game aims to show people who have experienced depression that they are not alone in their feelings, and to explain to others how depression can affect people. Wii works through increasing behavioural activation and physical activity.

Does it work?

There are several good evaluations demonstrating positive impacts from use of computer-aided therapy with older people in Australia and overseas. These therapies are effective in reducing symptoms of both anxiety and depression.

Less evidence is available on computer games, but a small study in a Japanese residential care setting showed some impacts of video games on symptoms of depression. An Australian study on teaching older women living in the community to use Wii showed that learning to play resulted in perceived improvements in physical, social and emotional wellbeing.

Considerations

Compared to face-to-face psychotherapy, computer-aided therapy requires less therapist time, provides prompt access to care, and saves travel time. It also gives people more privacy and more flexibility in how they access help. However, not all older people feel comfortable using a computer or other electronic devices. It is important that computer games are enjoyable and comfortable for older players, and that encouragement is provided.

No special training is required to implement programs to introduce older people to online therapies or computer games, but having IT backup is essential.

Recommendation

Computer-aided therapy can work for older people to reduce symptoms of anxiety and depression. Use of computer games may also have other positive impacts. This category of interventions is particularly relevant to people living in rural and remote areas.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Ageing Well at Home with Broadband is a real time exercise program, designed by the National Ageing Research Institute (NARI), which is ideal for people who find it difficult to attend a gym. It uses computer games to engage older adults in physical activity and enables older people to connect with others via the internet in order to participate in an exercise program. It also offers motivation and support and aims to reduce feelings of social isolation. The use of avatars means that movements can be tracked but judgements cannot be made on another's physical appearance.

The program is being trialled in Brunswick, Victoria. People participating in the trial have received a broadband connection and an Xbox, and are able to exercise alone or in a virtual group of four together with an instructor.

Case study

The Wellbeing Plus Course is an intervention based on cognitive behaviour therapy, developed with funding from *beyondblue*. This treatment is delivered online or by post with weekly telephone support from a mental health professional.

More than 500 older people have now completed the course. Some lived alone at home or with a partner, whereas others lived in residential care. All were experiencing anxiety or depression, or in many cases, both. For many people these symptoms were triggered or exacerbated by the loss of loved ones, transition to retirement, social isolation and lack of community connection, worry about the future and care of loved ones after they are gone, physical health issues or loss of independence. While some people were well linked in with community supports and care programs, others were socially isolated and had difficulty accessing support.

Most people reported improved mood and reduced anxiety. Many people reported increased motivation, improved sleep, increased social engagement, greater levels of physical activity and confidence in using relaxation strategies. Many people also described increased confidence in managing symptoms while remaining realistic about challenges they may face on the road to recovery. Many reported it was helpful to have family support as well to discuss the course. Regular contact with a therapist was both helpful and appreciated. Overall, feedback has been very positive. People were particularly appreciative of the support provided by their therapist and the variety of skills gained throughout the course.

Phone and telemonitoring

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	?	?

What is it?

Telemonitoring involves remotely monitoring clients who are not at the same location as the health care provider. A client has a number of monitoring devices at home. The results of these devices will be sent via telephone to the health care provider.

Support for people with a range of emotional issues may be provided by telephone and many organisations provide telephone support or information services.

How is it meant to work?

Treatments are similar to those delivered face-to-face. Delivering interventions via telephone is thought to be a cost-effective alternative to face-to-face treatments.

Does it work?

Only a small number of studies are available, and the findings from these studies are inconsistent. While one study found no benefit from this intervention, two others reported various benefits, such as improved mental health and self-care ability. A study with homebound older people concluded that managing depression by using existing home healthcare telemonitoring technology was feasible and participants showed improvements.

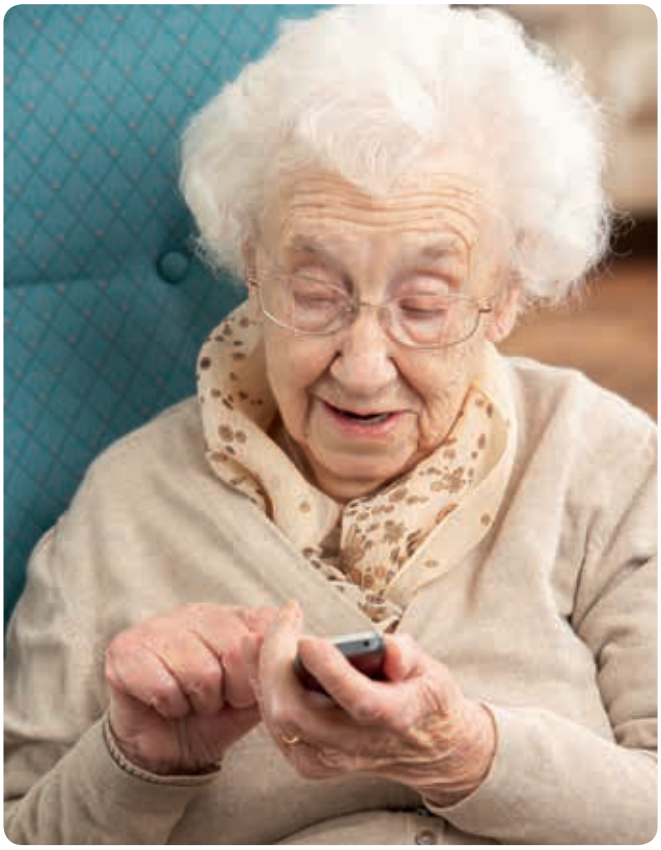
Considerations

Some older people may need assistance to make use of interventions that rely on telemonitoring, and people living with cognitive impairments need reminders so that benefits are sustained.

Recommendation

Interventions that rely on using the telephone or telemonitoring have some potential to improve the emotional wellbeing of older people, and may be especially useful in rural and remote areas or other circumstances where people have difficulty meeting in person, but we do not know if they work for anxiety and depression.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**



Robot companion

	Community settings	Residential care settings
Emotional wellbeing	?	👍 👍 👍
Anxiety	?	?
Depression	?	?

What is it?

Companion robots include AIBO (a metallic doglike robot), Paro (a white fluffy seal robot), and Matilda (an appealing small robot installed with software to recognise and respond to human emotions).

How is it meant to work?

Robot companions can play a role in assisting people similar to the role guide dogs have for visually impaired people. They can be a buddy providing companionship, a sense of safety, and support for social activity.

Does it work?

Research with companion robots in nursing homes has been conducted predominately with the companion robot AIBO (a metallic doglike robot) and Paro (a white fluffy seal robot).

There is not enough evidence from well-designed studies to know if robot companions improve wellbeing. However, one well-designed study found that, in comparison with the control group, residents who interacted with the robot reported feeling less lonely during the trial. Residents talked to and touched the seal robot significantly more than they did a live dog.

Considerations

Companion robots may offer similar benefits to live animals but require less care and are more hygienic. Companion robots are suitable for people with physical or cognitive impairments.

Some robot companions are complex machines and their use requires IT backup and support.

Recommendation

We do not yet know if robot companions can alleviate anxiety and depression. However, robot companions have the potential to provide comfort or decrease loneliness in people in residential care, including those living with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Matilda is a communication robot that has been designed to provide assistance to older people by enabling independence in the home. Matilda with her bright colours and humanoid appearance can use a variety of methods to support independence by keeping people socially connected, assisting with phone calls and bill payments, and giving reminders about medication. Matilda is also programmed to play music, read the newspaper or provide a weather report. She has also been programmed to lead bingo sessions.

Matilda incorporates emotionally intelligent software that can detect an individual's feelings through the tone in their voice. Matilda can respond appropriately by judging the person's feelings through voice tone and facial expressions.

A member of staff at The Boulevard residence at Mill Park, operated by Blue Cross, commented, "Matilda was a real hit with the residents and we are hoping that she will return to play some more bingo soon."

Matilda (belonging to NEC Japan's PaPeRo family of Robots) with a resident in The Boulevard facility.

Simulated presence therapy

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	?
Depression	?	?

What is it?

The intervention is used with people with dementia and consists of playing a recording of their carer's voice over a personal stereo. Video recordings may also be used.

How is it meant to work?

Hearing the voice of someone to whom the person with dementia felt close may help to make people feel more secure and to reduce anxiety when they are separated from their carers.

Does it work?

The evidence to support use of simulated presence therapy is weak. Case study evidence shows that the intervention may work to reduce anxiety for some people with dementia at least some of the time, and is more effective than listening to music. A review found some support for the use of simulated presence therapy and stressed the importance of assessing participants' suitability for such an approach and monitoring their responses closely.

Considerations

This intervention is likely to work only with older people who have had a secure and happy relationship with their family carer. Another study suggested that the most appropriate candidates for this intervention are those individuals with moderate to severe dementia (i.e. those who are unable to remember the content of the tape), who do not have a hearing impairment and who retain conversational skills. The technology involved is cost-effective and readily available. While no particular training is necessary to introduce simulated presence therapy, some skills in occupational therapy would be useful.

Recommendation

Simulated presence therapy is worth trying as a way to reduce agitation in a person living with dementia.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Quality of life approaches

Behavioural activation and pleasant events

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	👍👍👍	👍👍👍

What is it?

Behavioural activation (or behaviour therapy) focuses on increasing a person's level of activity and pleasure in their life, rather than changing the person's beliefs and attitudes. Behavioural activation can be carried out with individuals or groups, and generally lasts between eight and 16 weeks.

A more informal form of behavioural activation is to include a range of events in a person's daily routine that they will enjoy, such as bus trips and outings, social visits, religious activities, board games, bingo, or watching TV.

How is it meant to work?

Behavioural activation teaches people how to become more active and assumes there is an association between activity and positive feelings and emotions. These activities are thought to improve mood and overall have positive effects on older people's wellbeing.

Behavioural activation involves participating in pleasurable activities (e.g. spending time with good friends or engaged in hobbies) or activities that provide a sense of satisfaction. Some activities, such as exercising, carrying out a difficult work task or dealing with a long-standing problem, provides a sense of achievement. This helps to reverse patterns of withdrawal and inactivity that make depression worse, replacing them with rewarding experiences that reduce depression.

Interventions may combine behavioural activation with person-centred or restorative approaches to providing care. They work by providing opportunities for both active engagement and exercising choice and control, including for people with dementia.

Does it work?

Behavioural activation can be an effective therapy for depression and low mood. A study in a community setting found that a range of staff can be trained to successfully implement behavioural activation with diverse groups of frail older people. However, a review found behavioural activation was no more effective than the control group, cognitive therapy or brief psychodynamic therapy.

Behavioural activation has also been tested with family carers. It is effective in reducing symptoms of depression, stress and cardiovascular risk in older carers of family members with dementia.

We do not yet know if pleasant events by themselves improve symptoms of anxiety and depression. There is evidence that some of the stress of caring for a person with dementia may be alleviated by sharing enjoyable activities.

An evaluation showed that the Enriched Opportunities Program (see case study opposite) was effective in reducing symptoms of depression, compared with a control group.

Considerations

Improving the quality of life of older clients or residents through enjoyable activities should be a goal for all staff working in community or residential aged care settings. While formal behaviour therapy should be undertaken only by trained mental health practitioners, involving residents and clients in pleasant, rewarding activities can be undertaken by all staff in aged care settings. No special training is required to run activities programs, though skills in diversional therapy, occupation therapy or social work would be helpful.

Recommendation

Behavioural activation can be an effective treatment for depressed older adults. Participation in pleasant events and activities has the potential to improve mood and emotional wellbeing of older people and their carers.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The Enriched Opportunities Programme (EOP) is a multi-level intervention from the UK, designed to improve the quality of life of those with dementia or other significant wellbeing challenges. It was implemented at four sites, including three dementia-specific nursing homes and one housing scheme. EOP consisted of five essential elements:

- A senior member of staff was employed to be part of the senior team and to work with individuals who were seen to be at risk of poor emotional wellbeing.
- Individualised assessment and case work were used to identify types of interventions, occupation and activities that were most likely to promote well-being and to help individuals achieve their goals.
- A variable, flexible and practical programme of activity was implemented.
- Staff were trained and mentored.
- Management was committed to the project and provided leadership.

A key factor in the development of the EOP was trying it out in real-life situations in a controlled manner and receiving on going feedback from the sites where it was being piloted. The EOP was implemented consecutively in four sites, with enough time between each to allow expertise and practical techniques to be developed and shared.

The process of implementing EOP and the impact on people's lives has been very positive. Residents rated their quality of life more positively and reported decreased symptoms of depression over time and more social support and social inclusion.

Case study

The Book Well Program in Victoria was inspired by the United Kingdom's Get Into Reading program. Each week, small groups of about ten people listen to short stories and poetry slowly read aloud. The group members may then respond to what they have listened to. Some people voice their thoughts; others stay silent. It is an opportunity to be with people without the pressure of having to interact. The groups usually run for approximately one-and-a-half hours and include sharing refreshments.

The Book Well model has been adapted to make it more accessible for people living with dementia. Shorter, stand alone, texts and poetry are chosen. Texts used are printed in a larger font to assist those who want to read along, although some prefer to actively listen rather than follow the written word. The facilitator reads slowly and loudly and also takes time to explain parts of the story. The sessions are often shorter in duration than the usual group session timeframe.

A woman in her late eighties, living in an aged care facility, said about attending a Book Well group, "I enjoy most, and look forward to the most, doing something with my brain. This group has changed my mental health – yes! For the better."

Dementia care mapping

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	?
Depression	?	?

What is it?

Dementia care mapping (DCM) is based on a person-centred approach to care (see page 95). It is an observational tool intended to improve the quality of life of people with dementia living in residential care settings. It attempts to take the standpoint of the person with dementia, using a combination of empathy and observation. It takes place in communal areas and describes the behaviours of both the staff and people living with behaviour. The person doing the mapping also observes and rates the relative state of wellbeing experienced by the person with dementia. DCM is only available through licensed trainers.

How is it meant to work?

DCM works by moving dementia care from primarily a task-focused model to one that respects people with dementia as individuals.

Does it work?

In 2001, an international 'think tank' of DCM practitioners agreed that when DCM was used within an organisation to support person-centred care, it could improve levels of wellbeing, increase diversity of activities, and decrease staff behaviours that have the potential to reduce the resident's sense of personhood. Although one critical review suggested DCM cannot be said to categorically improve quality of life, a well-designed Australian study showed that implementing either person-centred care or DCM can reduce agitation and improve wellbeing in people with dementia in residential care.

Considerations

DCM needs a large investment of time and can be undertaken only by staff who are specially trained. Training is available in Australia from providers who are trained and licensed by the University of Bradford in the UK.

Recommendation

There is some evidence that DCM may improve the quality of life of people with dementia living in residential care facilities. It is a potentially useful tool in a field where few exist to improve practice.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

The 12 older people's champions at Dewsbury and District Hospital in the UK, including ward nurses, porters and care staff, were surprised and deeply moved by their training in dementia care mapping.

"Dementia care mapping is a very thought-provoking experience," says Fay. She and a colleague observed a woman's experience of the lunchtime routine. "We sat quietly in the corner. People were aware of us at first but they forgot we were there within about 10 to 15 minutes. First of all, I was amazed by the level of noise in the room. There was no shortage of staff, and they all came in en masse – very noisily. And they tended to talk over the patients. No one was unkind or unpleasant, but they were all focused on the job they had to do, not on the patients' experiences." It was clear the woman they were observing, who had dementia, was not enjoying the mealtime. "She had fleeting periods of ill-being throughout. She looked particularly distressed at one point because the nurses accidentally forgot to give her lunch – although they quickly noticed and apologised, and gave her a meal."

Another nurse said, "One day, two of us were mapping in a bay with four elderly clients who were clearly bored. A member of staff walked in and walked out again without speaking to any of them. Then a nursing auxiliary came in and said a cheery 'Good morning. How is everyone?' You could see the difference she made immediately – it brought the clients into a state of positive wellbeing." The experience of the sessions has made her reflect on everything she has done since she first started working with older people. "You look back and think, 'How could I have done that?'"

Person-centred care

	Community settings	Residential care settings
Emotional wellbeing	?	👍👍👍
Anxiety	?	👍👍👍
Depression	?	?

What is it?

Person-centred care is a philosophical approach to service delivery and service development, ensuring that older people and/or their carers are partners in care (see page 90). Person-centred care and related approaches (such as consumer-directed care, dementia mapping, emotion-oriented care and relationship-centred approaches) have been used in residential and community care settings to give clients and residents more choice and control in their everyday lives.

Relationship-centered care (RCC) recognises that the nature and the quality of relationships are central to effective care. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another.

How is it meant to work?

These approaches rely on treating clients and residents with dignity and respecting their autonomy, as far as possible, to make decisions for themselves. They encourage staff members to adopt more positive attitudes towards clients and residents.

Does it work?

Person centred care is difficult to study because it can range from a single intervention to an organisation-wide approach. A well-designed study in Australia has shown that person-centred care and an alternative approach, dementia-care mapping, both reduce agitation in people with dementia in residential care. This study also used a measure that included symptoms of anxiety and depression, but the interventions had no impact on residents' scores on this measure. Other studies have also shown that person-centred approaches are valued by older people and may have a positive impact, but anxiety and depression have not been directly measured as outcomes.

Considerations

Person-centred care and related models such as relationship-centred care are the gold standard for all staff working in aged care.

Recommendation

There is little scientific evidence that person-centred approaches reduce symptoms of anxiety or depression, but they may be usefully employed to address other issues, such as agitation, and to improve residents' quality of life and relationships between staff and residents.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

When a new resident was admitted to the residential care facility, activity staff focused on the roles this man previously had in life and how they could accommodate them now that he was in the facility. His role as a home maintenance man was important to him. The activity staff worked with management and provided some resources for him to engage in minor maintenance within the facility, for example, maintaining the fish pond and managing his own garden bed. This opportunity provided the man with the ability to engage in self-directed activities, with a sense of purpose and achievement, while contributing to the facility's outdoor maintenance.

Case study

Maria is an 82 year old widowed lady who has lived in Australia for 52 years. She came from Italy with her new husband and made a life for herself and her family. She lives at home by herself. Janice, who provides her with personal care, noticed that she is often in bed when she arrives and she struggles to get Maria going in the mornings. However, when she visited later in the day Maria was often brighter and in a better mood.

One day, Janice was intending to help Maria with her shower and getting dressed for the day but decided instead to sit with her in the kitchen and listen carefully to her over a cup of coffee. In that moment, Janice focused on who Maria was and how she was feeling, rather than being focused on doing the tasks she was scheduled to complete. Maria said that she was depressed about her life and bored. She cried most days and often felt she would be better off dead. She missed her children and felt she was a nuisance to them. After 20 minutes or so Maria was calmer and thanked Janice for being so kind. They went to the bathroom and Janice helped Maria shower and dress for the day.

When Janice returned to the office she talked to the care manager about Maria and together they worked out a plan to support her. They planned to begin each visit with time to sit and listen to Maria, and on the next visit to ask her whether they could help her to connect with the local Italian club or to go to a group where she could share her thoughts and feelings with others.

Restorative approaches

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	?	?
Depression	👍👍👍	?

What is it?

Restorative care is an optimistic approach. Restorative approaches (such as reablement and the Active service model being implemented in Victoria) are based on the assumption that even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing. It focuses on finding the solutions to support each individual's aspirations to maintain and strengthen their capacity to continue with their activities of daily living and social and community connections.

How is it meant to work?

Older people's emotional wellbeing is enhanced by becoming involved in identifying goals that are important and meaningful to them, and participating in decisions that affect their lives.

Does it work?

There is convincing evidence that restorative approaches are effective in reducing people's dependence on care. One UK study showed improvements in health and quality of life for the individuals receiving reablement. Individuals rated reablement as having a positive impact on their confidence and independence.

Considerations

Restorative models of care are increasingly being implemented in community care settings. Careful assessment of needs and abilities should be undertaken and activities integrated into care plans.

Recommendation

Restorative approaches to care are particularly useful when older people are able to articulate their goals and hopes and staff are able to find ways to assist them. There is some evidence that restorative approaches reduce symptoms of depression, and they may be used to address physical capacity, social participation and overall quality of life.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Mrs C is 81 years old and lives alone. Following a stroke, Mrs C stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening. The assessor who saw Mrs C focused on her strengths and abilities as well as her needs. Together they discussed what Mrs C would most like to achieve from a support plan. Mrs C's expressed goals were to get stronger, resume her church activities, do more about the house and get back out in the garden.

After mastering basic strength and balance exercises, Mrs C progressed from using a frame to a walking stick when out and was eventually able to walk unaided inside her home. A more confident Mrs C then arranged a 'buddy' to drive her to and from church activities in return for a home cooked meal one night a week. After six months, some housework tasks were moved from the 'I can do with help' to the 'I will do' category. Mrs C needed fewer hours of domestic assistance each week. She was delighted to find that new raised garden beds, dry spell planting and better mulching reduced the amount of garden maintenance needed without affecting her enjoyment of the garden.

Case study

Isabelle is a long-term community care client with an intellectual disability and hearing impairment who is able to lip read. She was admitted to a service after a 12-week stay in several inpatient facilities following surgery. As a result of her condition, Isabelle had a colostomy and became very dependent on staff both psychologically and physically. Despite the advice of many healthcare professionals, her case worker of more than 10 years was determined to help Isabelle 'give it a go' once again living independently in her unit and attending day programs.

Over a period of three months, Isabelle did return to a similar level of functioning, but was completely dependent on the District Nursing Service (DNS) for showering and colostomy care. The service discovered Isabelle had already talked about her goals, only staff weren't listening to her. She wanted to be able to shower when she pleased, without waiting for staff, and be able to manage her colostomy in a crisis. Staff used clip art and picture boards to communicate the care plan, and reassured Isabelle that they would continue visiting to support her. Many strategies were developed to help Isabelle achieve her goals, and one morning she opened the door freshly showered with lipstick in place and declared, "Isabelle's a good lady!"

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Interventions for carers

Education, social support and skill-building

Emotional wellbeing	
Anxiety	
Depression	

What is it?

This intervention focuses on the use of educational techniques, methods and approaches to reduce mental health problems or maintain wellbeing. Education for carers often includes providing knowledge about the condition of the person they care for and common carer issues, and can help carers to develop better coping strategies or other skills. While education may be provided one-to-one it is often delivered in group settings.

Support groups are included because these groups rarely provide only social support: they often include an educational component as well.

How is it meant to work?

Education may be offered to family carers on the basis that the more knowledge and information carers have, the more positive the outcomes may be for both the carer and the other person. It may:

- help carers to understand both their own experience and the experience of the person they care for
- coach carers in new skills
- provide social support, particularly if offered in a group setting
- help carers to develop strategies to deal with their situation.

Does it work?

Several reviews suggest that education and skill-building interventions can have a positive impact on anxiety and depression in carers of people with dementia. Some studies show improvements in the intervention group, while others show that emotional wellbeing is stable in people in the intervention group but declines for the control group. While most studies have included younger as well as older carers, some have focused on spouse caregivers.

One study looking at spouse caregivers compared a structured health education program with usual care for older adults who have a chronic health condition. The program included coping strategies, education about resources for carers and social support. The program was more effective than usual care in reducing depression in carers, and these effects lasted for a year after the program was completed. The intervention also prevented increases in symptoms of anxiety in frail older adults.

There is much more evidence on the intervention's impact on symptoms of depression than on anxiety, and much more on caring for people with dementia than those with physical frailty or other conditions. A review showed that social support alone is not effective.

Considerations

Educational interventions and groups may be difficult for carers to attend because of their caregiving responsibilities. Some skills-building programs require carers to keep records of how they respond to the other person's behaviours, such as diaries, and experience shows that these strategies work well for some carers but not others.

Recommendation

Educational and skills-building programs combined with social support are effective interventions for carers in community settings and have been shown to reduce symptoms of depression or to prevent depression from worsening. These programs can also assist with carers' anxiety.

Case study

Alfred Health in Melbourne designed and implemented a program for carers of people with dementia called Creative Ways to Care. This six-session program aims to provide family carers with the knowledge, skills, resources, and confidence to improve the quality of their everyday lives and respond positively to behaviours of concern. Sessions focus on increasing carer's knowledge of dementia, and identifying activities that carers can enjoy with their family member: reminiscence, aromatherapy and massage, music, and creative arts. Helpful techniques are taught, such as having a 'grab bag' of materials ready to bring out when needed.

An evaluation showed that the intervention was successful in increasing carers' ratings of their confidence, happiness, and enjoyment of the relationship with the person they cared for. The social support that people experienced emerged as very helpful. As one participant said: "It was a lovely group. I keep in touch with others in the group and the facilitators. I feel supported. Everyone got a chance to air problems. We all got on famously. You could nod your head and say you were having the same problem."

Interventions that rely on technology

Emotional wellbeing	
Anxiety	
Depression	

What is it?

Some interventions rely on using the telephone or computers to assist carers.

How is it meant to work?

Interventions differ but may provide information, coaching or individual or social support.

Does it work?

One study of carers (55 per cent spouses) found that a telephone support intervention reduced symptoms of depression only in those who began with very high levels of depression. This intervention included weekly conversations with carers, access to an online mailbox and bulletin board, similar to a chat group, and a conversation module designed to distract and calm care-recipients.

Another study looked at the effectiveness of a computer-telephone system that allowed carers to access information about resources and to participate in online discussion groups as often as they wished. Some participants received this system in combination with family therapy (a branch of counselling that deals with whole families), while others received only the family therapy or minimal support. Generally the family therapy intervention by itself did not have a significant effect on depression for most caregivers, but when combined with a readily accessible computer-telephone technology did reduce depression for most carers.

Considerations

It is not clear yet which groups can benefit most from telephone-based interventions. Setting up systems that rely on technology requires heavy investment initially, but may be more cost-effective in the long term than interventions that rely on staff to be present. These interventions should include arrangements for technical support.

Recommendation

While there is some evidence that they may be useful, technology-based interventions require more investment in design and evaluation before they can be used confidently with carers.

Mindfulness-based approaches

Emotional wellbeing	
Anxiety	
Depression	

What is it?

Mindfulness-based approaches rely on a type of meditation that teaches people to focus on the present moment, just noticing whatever they are experiencing, including pleasant and unpleasant experiences, without trying to change them. At first, this approach is used to focus on physical sensations (like breathing), but later it is used to focus on feelings and thoughts.

How is it meant to work?

This approach helps people to change their state of mind so that they can experience what is happening right now. It stops their mind wandering off into thoughts about the future or the past, or trying to avoid unpleasant thoughts and feelings. This may be helpful because it allows people to notice feelings of sadness and negative thinking patterns early on, before they have become fixed. It therefore helps the person to deal with these early warning signs better.

Does it work?

There is some evidence that mindfulness can assist to reduce symptoms of anxiety and depression in carers, but this evidence is not very strong.

Considerations

Being able to learn and benefit from meditation and mindfulness avoids the stigma that may be associated with therapy. Mindfulness approaches should only be undertaken by trained therapists.

Recommendation

Mindfulness-based approaches are promising interventions for carers, but more evaluation needs to be done before we can be confident they work.

Psychological interventions and counselling

Emotional wellbeing	
Anxiety	
Depression	

What is it?

Interventions delivered by psychologists and counsellors generally rely on a trained therapist building a relationship with a person and focusing on the person's thoughts and feelings. Specific interventions of this type are described in the section 'Interventions delivered by mental health professionals', on page 109.

How is it meant to work?

Psychological interventions enable people to deal with their thoughts and feelings within a supportive relationship and to make important changes in their lives.

Does it work?

Two well-designed studies from the US showed that providing family carers with traditional weekly sessions with a therapist results in lower levels of anxiety and depression, improved use of coping strategies, and higher self-esteem. Another study has shown that cognitive-behavioural therapy (CBT) has a positive impact on carers' symptoms of depression and the stress of being a carer and general life stress. Behavioural activation (see page 90) has also been shown to work with family carers.

One study undertaken in the USA, the UK and Australia showed that a combination of individual and family counselling helps to reduce symptoms of depression in spouse carers who are also taking medication for depression, and is more effective than just taking the medication.

Considerations

Similar to other older people, carers may be reluctant to make use of psychological interventions or counselling. Psychological interventions and counselling should be undertaken only by trained mental health professionals.

Recommendation

Psychological interventions and counselling for older carers are worth considering, especially for those who do not wish to attend a group.

Mixed interventions

Emotional wellbeing	
Anxiety	
Depression	

What is it?

Many studies have used combinations of the strategies outlined above to reduce depression in carers of people with dementia.

How is it meant to work?

Interventions combining several strategies attempt to help carers on several levels at once.

Does it work?

Several studies have tried a mix of strategies with caregivers of people with dementia. Three have used very strong research designs and have either included a large proportion of spouses or have analysed their results by caregiver relationship type. It is clear that mixed interventions (or multi-component interventions) have relatively high success rates in reducing depression in carers of people with dementia.

Mixed interventions usually include support groups (face-to-face or using the telephone) and either individual or family counselling. Several of these studies have included only spouse carers. For example, the New York University Spouse-Caregiver Intervention study randomly allocated 320 carers either to a 'usual care' group, which received information only, or to the intervention group, which received a comprehensive intervention including individual and family counselling and a weekly support group. The intervention group had fewer symptoms of depression for three years after being recruited to the study. A study using the same group of carers explored reasons for the effectiveness of the intervention and found changes in social support were largely responsible. The intervention increased the amount of assistance carers were receiving, the number of people in their support networks, and their satisfaction with the social support they were receiving.

Considerations

Mixed interventions may take more resources to implement than single interventions.

Recommendation

Offering several types of support to carers is more likely to be successful in reducing symptoms of depression than a single component intervention.

Key to thumbs up scale	
	At least three high quality studies show that the approach works
	At least two good quality studies show that the approach works
	There is some evidence that the approach works but the amount of evidence is small or the quality of the evidence is not very strong
	There is not enough evidence to show whether the approach works or not.

Interventions delivered by mental health professionals

Acceptance and commitment therapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	👍👍👍	?
Depression	👍👍👍	?

What is it?

Acceptance and commitment therapy (ACT) is a type of cognitive behaviour therapy (CBT, see page 112). However, it is different from CBT because it does not teach people how to change their thinking and behaviour. Instead, ACT teaches them to 'just notice' and accept their thoughts and feelings, especially unpleasant ones that they might normally try to avoid. This is because ACT therapists believe it is unhelpful to try to control or change distressing thoughts or feelings. In this way, it is similar to mindfulness-based approaches. ACT usually involves individual meetings with a therapist.

How is it meant to work?

ACT helps people accept difficult emotions and avoid 'over thinking' their experiences. Over thinking occurs when people focus on their 'self talk' rather than their present experiences. ACT encourages people to accept their reactions and to experience them without trying to change them. Once the person has done this, he/she is encouraged to respond to situations in ways that are consistent with their life goals. The person is then encouraged to put those choices into action.

Supportive therapists believe that for some people with long-term problems, the most helpful approach is to provide them with a reliable, accepting counselling relationship. This helps them cope with the challenges of day-to-day life and is especially useful for dealing with long-term problems that are difficult to change. The relationship of support and acceptance with the person's therapist is critical to helping the person to cope better, even if the person cannot change many of the problems he/she is facing.

Does it work?

ACT has not been sufficiently evaluated in older people. We know from one small study that it is feasible in older people and may be effective in reducing symptoms of depression and worry, even when conducted by novice therapists.

Considerations

This therapy should be used only by trained mental health professionals.

Recommendation

ACT may be an effective treatment for anxiety and/or depression in older people, but more evaluations are required before we can be sure.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Joe was a 60 year old divorced man presenting to the clinic with problems with anxiety and depression. Over the previous 10 years, Joe had difficulty coping with many stressful life events. Joe's wife divorced him, his sister died of breast cancer, he was diagnosed with diabetes and he lost his job and had to ask his son for financial support. Joe's problems were conceptualised using an ACT approach. Joe was stuck in a view of himself characterised by focusing on when he was successful, had his own house, went to work, and felt closer to his family. He feared that his health was going to deteriorate and that his son was going to reject him. He had difficulty labelling thoughts or feelings and would just describe himself as being "very tired." Joe had given up looking for work and spent a lot of time in bed most days.

Joe's treatment plan consisted of 12 sessions with the following goals: (a) reconnect Joe to his values and identify how his current behaviours do not assist him with things he values most; (b) increase Joe's awareness of his thoughts and feelings; (c) increase Joe's willingness to experience emotions; and (d) increase positive behaviours. Mindfulness was practiced at the beginning of every session. Initially, Joe worked to take small steps that would bring him closer to his goals, such as cleaning up after his breakfast, shaving, showering, and getting out of his pyjamas every day. By later sessions Joe was applying for at least one job a week, was actively contacting old friends in his field to inquire about job openings, and was spending time with his son once a week.

Cognitive behaviour therapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	👍👍👍
Depression	👍👍👍	👍👍👍

What is it?

In cognitive behaviour therapy (CBT), people work with a therapist to look at patterns of thinking (cognition) and acting (behaviour) that are making them more likely to have problems with anxiety and/or depression, or are keeping them from improving once they become anxious or depressed. Once these patterns are recognised, the person can then make changes to replace these patterns with ones that reduce anxiety and/or depression, promote good mood and improve coping. It can be conducted in individual meetings with a therapist, or in groups. Treatment length can vary, but is usually conducted over four to 24 weekly sessions.

Behaviour therapy is a related intervention. Mental health professionals who practice behaviour therapy tend to focus on specific, learned behaviours and how the environment has an impact on those behaviours. Many therapists work with both CBT and behaviour therapy. Acceptance and commitment therapy (see page 110) is another variation on CBT.

How is it meant to work?

Anxiety

CBT is thought to work by helping people to recognise patterns in their thinking and behaviour that make them more vulnerable to anxiety. For example, thinking that is focused on threats and dangers are often linked with anxiety. In CBT, the person works to change these patterns to use more realistic and problem-solving thinking. As well, anxiety is often increased when a person actively avoids things of which he/she is afraid. Learning to face up to situations that are anxiety-provoking is also often helpful.

Behaviour therapies may include behavioural activation (see page 90) or relaxation training and techniques such as flooding implosion therapy and in vivo exposure and systematic desensitisation (see the list of therapies reviewed but no research evidence was found, page 123). They work by removing the link between the thing or situation that causes anxiety and the person's response to it.

Depression

CBT is thought to work by helping the person to recognise patterns in their thinking and behaviour that make them more likely to become depressed. For example, very negative, self-focused, and self-critical thinking is often linked with depression. In CBT, the person works to change these patterns to use more realistic and problem-solving thinking. As well, depression is often increased when a person stops doing things they previously enjoyed. CBT helps the person to increase activities that give them pleasure or a sense of achievement. This is the behavioural component of CBT.

Does it work?

CBT has been tested in well-designed studies and found to be effective for anxiety and depression. It is effective for older adults in residential care and community settings, as well as for carers.

Considerations

CBT on its own is shown to be an effective intervention for mild to moderate depression in later life and can be a treatment alternative for those who cannot tolerate medications. CBT can be provided only by mental health professionals.

Recommendation

CBT is one of the most effective treatments available for anxiety and depression and is easily adapted for use with older clients.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Cognitive behaviour therapy (CBT) was implemented for older community care clients with anxiety and depression. The program was conducted by a psychologist over a series of eight weeks in clients' homes and with telephone support between sessions. Therapists worked with each older person to develop a set of goals to achieve and helped them to use problem-solving techniques and coping strategies. The therapist also implemented regular relaxation sessions.

The clients found the CBT sessions particularly helpful to manage stressful situations, which they may have previously avoided. The program was also effective in assisting to reduce or manage anxiety and depression. Several clients noted that the sessions were useful to achieve daily goals that previously seemed overwhelming.

Interpersonal psychotherapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	👍👍👍	?

What is it?

Interpersonal psychotherapy (IPT) focuses on problems in personal relationships and on building skills to deal with these problems. It was originally designed to treat depression. IPT is based on the idea that these interpersonal problems are a significant part of the cause of the emotional problems. It focuses on personal relationships, rather than what is going on in the person's mind (e.g. thoughts and feelings). Treatment length can vary, with IPT usually conducted over four to 24 weekly sessions.

How is it meant to work?

IPT is thought to work by helping people to recognise patterns in their relationships with others that make them more vulnerable to emotional problems like anxiety and depression. The person and therapist focus on specific interpersonal problems, such as grief over lost relationships, different expectations in relationships between the person and others, giving up old roles to take on new ones, and improving skills for dealing with other people. By helping the person to overcome these problems, IPT aims to help the person to control his/her anxiety and/or improve their mood.

Does it work?

IPT is useful for preventing and treating symptoms of depression in older adults in community settings.

There is evidence from one study that IPT is effective in addressing anxiety about social situations (social phobia). Residents with early onset of social phobia and poor general functioning experienced the least improvement with this treatment.

Considerations

Ethnic diversity needs to be considered when implementing and assessing therapeutic interventions. Where people have cognitive impairment, IPT may need to be adapted to meet their needs. This therapy should be used only by trained mental health professionals.

Recommendation

IPT has potential as a treatment for depression in older people, but more evaluation is required before we can be confident it works.

Life review therapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	👍👍👍
Depression	👍👍👍	👍👍👍

What is it?

Life review therapy is a structured intervention used mainly with older people with depression. It involves encouraging people to remember and review memories of past events in their lives. It involves focusing on resolving conflicts and regrets linked with past experiences. The person can take a new perspective or use strategies to cope with thoughts and feelings about these events. Life review therapy can be used in groups.

How is it meant to work?

Life review therapy is focused on reducing bitterness and boredom and promoting a positive view on the past. Resolving conflicts and developing a feeling of gratitude for one's life are thought to help reduce feelings of despair.

Does it work?

A review found that life review therapy works for depression, at least in the short-term. Its use with anxiety is currently being evaluated formally in the Netherlands through a program called 'The stories we live by'.

Considerations

Therapeutic life review may be cost effective. Professional training is required to deliver and implement this intervention effectively.

Recommendation

Life review therapy appears to work for depression and may prove to work for symptoms of anxiety.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Jane was a 92 year old widow who was experiencing depression. Staff noted that Jane had become withdrawn from social activities. A counsellor was asked to assist Jane to help improve her mood. The counsellor used a reminiscence based approach, during which Jane revealed her passion for food and cooking. The counsellor noted that Jane's mood improved when they were discussing family recipes and suggested they create a recipe book that could be shared with her family. Through the telling of recipes, Jane recalled poignant and pleasant memories of her family and her life's work.

Over the course of the weekly counselling sessions, Jane and the facility staff noted her improved mood and social engagement. Jane was able to reconnect with her identity and feelings through the discussions about recipes.

Case study

'The stories we live by' was conducted in groups of four to six participants and consisted of eight two-hour sessions. The first five intervention sessions were focused on different life themes: childhood, youth, work and care, love and conflicts, and loss and difficult times. Before each session, participants were given questions about those life themes and were asked to describe one difficult life event they are still struggling with. Then they answered questions that guided them to develop alternative stories to help deal with this life event. At each session they were also asked to describe a specific positive memory. During the sessions, participants had opportunities to discuss their experiences with each other.

An evaluation of this pilot intervention showed promising results for reducing symptoms of depression.

Mindfulness-based approaches

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	👍👍👍
Anxiety	👍👍👍	?
Depression	👍👍👍	👍👍👍

What is it?

Mindfulness-based approaches include mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT). Both approaches rely on mindfulness, which is a type of meditation that teaches people to focus on the present moment, just noticing whatever they are experiencing, including pleasant and unpleasant experiences, without trying to change them. At first, this approach is used to focus on physical sensations (like breathing), but later it is used to focus on feelings and thoughts.

Usually, MBSR is an eight-session course with an additional day of meditation. MBCT is generally delivered in groups and is used to prevent the return of symptoms of depression in people who have recovered from an episode.

How is it meant to work?

Both approaches help people to change their state of mind so that they can experience what is happening right now. It stops their mind wandering off into thoughts about the future or the past, or trying to avoid unpleasant thoughts and feelings. This is thought to be helpful because it allows people to notice feelings of sadness and negative thinking patterns early on, before they have become fixed. It therefore helps the person to deal with these early warning signs better.

Does it work?

MBSR has not yet been properly evaluated in well-designed studies. One study found that MBSR improves positive emotions for older people with mild symptoms of depression. In another study, participants became less anxious and experienced significant improvements in memory.

MCBT has been found to be effective in older people in reducing symptoms of depression. It has also been found effective for post-traumatic stress disorder (PTSD) in a residential treatment program for veterans.

Considerations

Being able to learn and benefit from meditation and mindfulness is less stigmatising than requiring therapy. This benefit is enhanced by the way mindfulness-based approaches require people to work with what is right for them and what people have in common, in contrast to more problem-focused approaches. Mindfulness therapies should be undertaken only by trained therapists.

Recommendation

Mindfulness-based approaches are promising interventions for older people with depression or symptoms of post-traumatic stress.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Narrative therapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	?	?

What is it?

Narrative therapy is an approach to psychological therapy that focuses on how people think about themselves and their life situations in terms of narratives, or stories. People attend psychological therapy either alone or with their partner or family. This therapy was developed largely in Australia and has been used with Aboriginal and Torres Strait Islander (ATSI) people.

How is it meant to work?

The theory behind narrative therapy proposes that people's problems are partly caused by the language used to describe them. People tell themselves stories about their difficulties and the life situations in which they occur. Some of these stories can increase depression, especially where the person sees himself or herself as powerless or unacceptable. Older people may have personal narratives that focus on themes of loss and dependency. Narrative therapy may help them develop alternative stories that focus on their strengths.

Does it work?

The use of narrative therapy with older people has not yet been properly evaluated in well-designed studies. A small Canadian study trialling group-based narrative therapy with older people living in the community showed participants experienced significantly improved emotional wellbeing.

Considerations

Narrative therapy should be undertaken only by trained mental health professionals.

Recommendation

Narrative therapy is a promising alternative therapy for use with older people, but we do not yet know if it is an effective treatment for depression or anxiety.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

Margaret and her husband moved into independent unit in a retirement village five years ago. Unfortunately Brian died six months ago and Margaret became quite depressed.

Margaret, normally quite social, increasingly became socially isolated, rarely leaving her unit and her neighbours became quite concerned about her. If she did go to social gatherings, Margaret was often teary and withdrawn. After a conversation with the manager of the facility, Margaret decided to visit her GP. Her GP referred her to a narrative therapist, Alice, for counselling. Margaret was apprehensive about the idea of counselling. In the first session Alice asked lots of questions about Brian, such as, "What had Margaret liked about him?" and "What sorts of things did she do with Brian?" and also "What has been the impact of his death after all these years?" Margaret came out of the session feeling sad but in some ways also uplifted. She had thought she had to let Brian go but Alice was more interested in knowing more about Brian and had asked, "I wonder what Brian would like you to take forward in your life of your time together?" and "What special qualities did Brian have that may help you in this time of grief?" Margaret really thought about those questions.

Margaret began to look forward to these sessions. While she missed Brian she loved being able to talk to Alice about him and she didn't feel those around her wanted or were able to talk to her like Alice. Margaret remembers a session where Alice pushed her a bit to re-engage more with her community. Margaret quickly responded "I already have!"

Problem-solving therapy

	Community settings	Residential care settings
Emotional wellbeing	👍👍👍	?
Anxiety	?	?
Depression	👍👍👍	?

What is it?

Problem-solving therapy (PST) is a brief psychological intervention usually provided over a series of four to eight sessions. During these sessions the therapist and client work together to identify problems in the client's life, and then focus on one or more of these. The therapist teaches the client a structured approach to solving these problems, as well as focusing on improving the client's general approach to problems.

How is it meant to work?

New problem-solving skills can be applied to specific life problems that are associated with poor emotional wellbeing or symptoms of anxiety and depression.

Does it work?

Several small studies have shown that problem-solving therapy works for older people living in the community with relatively mild depression.

Considerations

Standard PST can be adapted to suit older people, by providing therapy in their homes and tailoring it to address the particular stresses they are experiencing. There is no evidence that PST works for symptoms of anxiety. PST should be undertaken only by trained mental health professionals.

Recommendation

Problem-solving therapy is a useful intervention for older people living in the community whose symptoms of depression are relatively mild.

For additional information about this intervention, visit **www.beyondblue.org.au/whatworkslinks**

Case study

In one study, standard PST was adapted in several ways for homebound patients with symptoms of depression and coexisting medical illness. Brief PST was provided in patients' homes in six weekly one-hour sessions. The therapist, a social worker, tailored the treatment protocol to the specific daily stressors of each individual patient. Patients were encouraged to schedule two pleasant activities each day. Educational brochures on the topics of depression and quality of life were used.

During the first session, patients learned about the links between symptoms of depression and chronic medical illness. The signs, symptoms, thoughts, and behaviours associated with depression were identified and reviewed, and participants were asked to describe problems from their own life experience to develop realistic treatment goals. Sessions also focused on medication adherence, diet and nutrition plans, exercise plans, signs of heart attack and stroke, and family relationships. Fact sheets and educational brochures on heart disease were also provided. During the sessions, participants spent time practicing their new problem-solving coping skills. Patients who received PST reported significant reductions in symptoms of depression and increased emotional wellbeing.

Interventions useful for people living with dementia or cognitive impairment

Research shows that the following interventions can promote emotional wellbeing in people living with dementia or a cognitive impairment.

More information on how to use many of the approaches featured in this booklet with people living with dementia can be found in:

Killick, J. (2012). *Playfulness and dementia: A practice guide.* London, UK: Jessica Kingsley.

Killick, J., & Craig, C. (2011). *Creativity and communication in persons with dementia: A practical guide.* London, UK: Jessica Kingsley.

Interventions reviewed but no research evidence found

Some interventions have not been used with older people, or their use has not been formally evaluated. While we were unable to find any evidence in the scientific literature about the following interventions, some may promote wellbeing in older people.

Applied muscle tension: a technique that involves deliberately increasing muscle tension to temporarily increase blood pressure to prevent fainting in situations that make people anxious.

Biofeedback: the use of immediate feedback on physiological functions such as muscle tone and heart rate with the goal of learning to control them.

Dialectical behaviour therapy: a therapy that combines cognitive behaviour therapy (CBT) with techniques to control emotions such as mindfulness.

Eye movement desensitisation and reprocessing (EMDR): a form of psychotherapy used to help resolve the symptoms of traumatic and other disturbing life experiences.

Flooding, implosion therapy and in vivo exposure: therapies for overcoming irrational fears or phobias by bringing the person in direct contact with (or getting them to imagine being in contact with) the thing they fear.

Hydrotherapy: the use of water jets, underwater massage and mineral baths for pain relief and treatment.

Hypnosis: the use of an induced, altered mental state that may involve heightened focus and concentration.

Juggling therapy: helping people achieve social skills through learning to juggle.

Neurolinguistic programming (NLP): an approach to personal development and psychotherapy that links brain developments, language, and behaviour.

Psychoanalysis: psychological techniques based on the theory that events in early childhood determine how a person develops and that people's attitudes and behaviours are influenced by unconscious irrational drives.

Rational emotive therapy (RET): a form of cognitive behaviour therapy (CBT) that focuses on resolving people's emotional and behavioural problems.

Theatre and psychodrama: the use of drama and role playing to help people gain insight into their lives.

Watsu: involves movement, stretching, joint mobilisation, and massage performed in warm water pools.

Planning your evaluation

An important part of implementing any strategy to assist your clients and residents is to plan an evaluation. The three basic questions to ask are:

1. What did you do?
2. How well was it done?
3. Did it make a difference to clients?

1. What did you do?

Here you should document, for example, what you provided, the number of clients or residents involved and the clients'/residents' characteristics. You may need to set up a basic table to help you record this information accurately, especially if your intervention is planned to involve several clients/residents and several staff, and to occur over a long period of time.

You might like to design a basic information sheet like the one below:

Why was this particular intervention chosen?	
How many clients/residents were involved in the intervention?	
Was the intervention delivered to individual clients or to groups?	
How and why were clients chosen for the intervention?	
How many sessions were involved?	
How long was each session?	
How frequent were the sessions? (e.g. several times a day, daily, weekly, fortnightly, or monthly)	
Were the sessions held at a particular time of day? (e.g. morning, afternoon, bedtime)	
How many staff members were involved?	
Where was the intervention carried out? (In people's homes? In a public venue?)	
How was the intervention carried out? (What routine was followed? What did staff actually do?)	
What was the cost of the intervention? (To clients/residents and to the organisation)	

Some of these questions will not be relevant for some interventions, so you will need to adapt this list to suit. If you are conducting several sessions, you may need a separate information sheet for each session so that you can track changes in what you did over time.

2. How well was it done?

An information sheet like the following may help you to answer this question.

How well did the intervention run?	☐ Very well ☐ Fairly well ☐ Not very well ☐ Not at all well
Comment:	
What helped your intervention to work?	☐ Timing ☐ Location ☐ Staff availability ☐ Staff motivation ☐ Staff skills ☐ Resources ☐ Support from managers ☐ Involvement of volunteers ☐ Involvement of family members ☐ Participants' health ☐ Participants' motivation
Comment:	
What prevented your intervention from working as well as you'd hoped?	☐ Poor timing ☐ Unsuitable location ☐ Staff not available ☐ Staff had low motivation ☐ Staff did not have enough skills ☐ Lack of resources ☐ Lack of support from managers ☐ Not enough volunteer involvement ☐ Not enough involvement of family members ☐ Participants' health was too poor ☐ Participants' motivation was too low ☐ Other factors, such as
Comment:	

Depending on the intervention, your evaluation may be needed just once after implementation, or several times. It might be helpful to design a short, one-page questionnaire for staff to complete, or have a meeting where you can discuss the issues and record staff members' views.

Some interventions will rely on the involvement of family carers and in this case you might want to talk with them periodically about how well they think the intervention is going and record their feedback.

3. Did it make a difference to clients?

This is the most significant question and the most difficult to answer.

Setting achievable goals

The first step in answering this question is to state at the outset what difference you want your intervention to make, in as specific terms as you can, making sure that your goals are achievable. Examples might be:

- To reduce Mrs A's scores on the Cornell Scale for Depression in Dementia (CSDD) from the moderate to the mild range.
- To reduce Mrs B's crying spells from an average of five days per week to two to three days per week.
- To reduce the amount of medication that Mrs C, Mrs D and Mr E take for anxiety by the end of the year.
- To reduce the number of residents in Z Unit whose agitation causes disruption to other residents at tea time.
- To reduce the number of days that Mr F refuses to come to the day centre, saying he does not feel up to it, from an average of three days per week to one day per week.
- To reduce the amount of 'shadowing' that Mr G does with his carer in the late afternoon (4–6 pm), from several times per day to three times per week.
- To reduce signs of distress (measured by observing facial expression post music therapy) in residents with severe dementia. (For comparisons you will need to have monitored their distress prior to music sessions.)

Measuring outcomes

The next step is to work out how you are going to measure your outcomes. How will you know whether your intervention has been successful or not? Sometimes measurement tools are already being used, such as the Cornell scale for assessing depression in dementia, or prn (as needed) medication charts. Community services may use attendance records or other counts, such as the number of delivered meals actually consumed. Family carers may complete a simple daily record sheet to note how often a behaviour occurs and (perhaps) how severe or constant it is.

Often, you will need to take some measures before you begin your intervention, so that you can compare the outcomes at the end. With people with severe dementia, it may be useful to record behaviour before and after each session. The behaviour might be something as simple as a person's facial expression or how restless they seem.

As well as recording things you can count, people's comments are often very useful. For example, staff members can be encouraged to write down verbatim comments, both positive and negative, that clients or residents make, or that family members make when visiting. It may also be useful to collect comments systematically at planned times. You could ask the older person: Do you think the program has had any impact on how you feel? You could ask family members: Have you noticed any changes in your relative's mood? What is the most significant change that you have experienced (or seen)?

It is important to note that if your intervention does not seem to have been successful, this does not mean that your efforts have been wasted. If you have kept good records, you will have learned something from the process of trying an intervention. You might want to ask yourself: How well was the intervention implemented? Was the right outcome measure chosen? Did the measure focus on the right things and was it sensitive enough to pick up any changes? Finally, you may want to ask whether the right intervention was chosen for the person or group, and whether a different approach might be more effective.

References

Physical activity

Exercise

Kerse, N., Hayman, K. J., Moyes, S. A., Peri, K., et al. (2010). Home-based activity program for older people with depressive symptoms: DeLLITE-A randomized controlled trial. *Annals of Family Medicine,* 8(3), 214-223.

Maki, Y., Ura, C., Yamaguchi, et al. (2012). Effects of intervention using a community-based walking program for prevention of mental decline: A randomized controlled trial. *Journal of the American Geriatrics Society,* 60(3), 505-510.

Pasco, J. A., Williams, L. J., Jacka, F. N., et al. (2011). Habitual physical activity and the risk for depressive and anxiety disorders among older men and women. *International Psychogeriatrics,* 23(2), 292-298.

Windle, G., Hughes, D., Linck, P., et al. (2010). Is exercise effective in promoting mental well-being in older age? A systematic review. *Aging & Mental Health,* 14(6), 652-669.

Gardening and nature-assisted therapy

Austin, E. N., Johnston, Y. A. M., & Morgan, L. L. (2006). Community gardening in a senior center: A therapeutic intervention to improve the health of older adults. *Therapeutic Recreation Journal,* 40(1), 48-57.

McCaffrey, R., Liehr, P., Gregersen, T., & Nishioka, R. (2011). Garden walking and art therapy for depression in older adults: A pilot study. *Research in Gerontological Nursing,* 4(4), 237-242. doi: 10.3928/19404921-20110201-01

Rappe, E., & Kivela, S. L. (2005). Effects of garden visits on long-term care residents as related to depression. *Horl Technology,* 15(2), 298-303.

Laughter therapy and laughter yoga

Ko, H. J., & Youn, C. H. (2011). Effects of laughter therapy on depression, cognition and sleep among the community-dwelling elderly. *Geriatrics & Gerontology International,* 11(3), 267-274.

Shahidi, M., Mojtahed, A., Modabbernia, A., et al. (2011). Laughter yoga versus group exercise program in elderly depressed women: A randomized controlled trial. *International Journal of Geriatric Psychiatry,* 26(3), 322-327. doi: 10.1002/gps.2545

Tai chi and qigong

Chi, I., Jordan-Marsh, M., Guo, M., et al. (2013). Tai chi and reduction of depressive symptoms for older adults: A meta-analysis of randomized trials. *Geriatrics & Gerontology International,* 13(1), 3-12.

Frye, B., Scheinthal, S., Kemarskaya, T., & Pruchno, R. (2007). Tai Chi and low impact exercise: Effects on the physical functioning and psychological well-being of older people. *Journal of Applied Gerontology,* 26(5), 433-453.

Lavretsky, H., Alstein, L. L., Olmstead, R. E., et al. (2011). Complementary use of Tai Chi Chih augments escitalopram treatment of geriatric depression: A randomized controlled trial. *The American Journal of Geriatric Psychiatry,* 19(10), 839-850.

Tsang, H. W. H., Fung, K. M. T., Chan, A. S. M., et al. (2006). Effect of a Qigong exercise programme on elderly with depression. *International Journal of Geriatric Psychiatry,* 21, 890-897.

Yoga

Chugh-Gupta, N., Baldassarre, F. G., & Vrkljan, B. H. (2013). A systematic review of yoga for state anxiety: Considerations for occupational therapy/ Revue systématique sur l'efficacité du yoga pour traiter l'anxiété réactionnelle: Facteurs à considérer en ergothérapie. *The Canadian Journal of Occupational Therapy,* 80(3), 150-170.

Fan, J.-T., & Chen, K.-M. (2011). Using silver yoga exercises to promote physical and mental health of elders with dementia in long-term care facilities. *International Psychogeriatrics,* 23(8), 1222-1230.

Litchke, L. G., Hodges, J. S., & Reardon, R. F. (2012). Benefits of chair yoga for persons with mild to severe Alzheimer's Disease. *Activities, Adaptation & Aging,* 36(4), 317-328.

Relaxation

Humour therapy

Low, L. F., Brodaty, H., Goodenough, B., et al. (2013). The Sydney multisite intervention of LaughterBosses and ElderClowns (SMILE) study: Cluster randomised trial of humour therapy in nursing homes. *BMJ Open,* 3(1).

Massage

Harris, M., & Richards, K. C. (2010). The physiological and psychological effects of slow-stroke back massage and hand massage on relaxation in older people. *Journal of Clinical Nursing,* 19(7-8), 917-926.

Moyle, W., Murfield, J. E., O'Dwyer, S., & Van Wyk, S. (2013). The effect of massage on agitated behaviours in older people with dementia: A literature review. *Journal of Clinical Nursing,* 22(5-6), 601-610.

Nelson, R., & Coyle, C. (2010). Effects of a bedtime massage on relaxation in nursing home residents with sleep disorders. *Activities, Adaptation and Aging,* 34(3), 216-231.

Suzuki, M., Tatsumi, A., Otsuka, T., et al. (2010). Physical and psychological effects of 6-week tactile massage on elderly patients with severe dementia. *American Journal of Alzheimer's Disease and Other Dementias,* 25(8), 680-686.

Meditation

Goyal, M., Singh, S., Sibinga, E. S., et al. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *JAMA Internal Medicine,* 174(3), 357-368.

Krisanaprakornkit, T., Sriraj, W., Piyavhatkul, N., & Laopaiboon, M. (2006). Meditation therapy for anxiety disorders. *Cochrane Database of Systematic Reviews*, CD004998.

Lindberg, D. A. (2005). Integrative review of research related to meditation, spirituality, and the elderly. *Geriatric Nursing,* 26(6), 372-377.

Reiki

Park, J., McCaffrey, R., & Goodman, R. (2011). Managing osteoarthritis: Comparisons of chair yoga, reiki and education. *Holistic Nursing Practice,* 25(6), 316-326.

Richeson, N. E., Spross, J. A., Lutz, K., & Peng, C. (2010). Effects of reiki on anxiety, depression, pain, and physiological factors in community-dwelling older adults. *Research in Gerontological Nursing,* 3(3), 187-199.

Relaxation training

Galvin, J. A., Benson, H., Deckro, G. R., et al. (2006). The relaxation response: Reducing stress and improving cognition in healthy aging adults. *Complementary Therapies in Clinical Practice,* 12(3), 186-191.

Gruden-Pokupec, J. S., Gruden, Z., & Gruden, V. (2011). The impact of psychological testing on the patients suffering from stomatopyrosis. *Collegium Antropologicum,* 35(4), 1167-1176.

Jorm, A. F., Morgan, A. J., & Hetrick, S. E. (2008). Relaxation for depression. *The Cochrane Collaboration* (4), 1-79.

Manzoni, G. M., Pagnini, F., Castelnuovo, G., & Molinari, E. (2008). Relaxation training for anxiety: A ten-year systematic review with meta-analysis. *BMC Psychiatry,* 8(41), 1-12.

Sensory stimulation

Aromatherapy

Holt, F., Birks, T., Thorgrimsen, L., et al. (2003). Aromatherapy for dementia (Review): Cochrane Database of Systematic Reviews 2003.

Lin, P. W., Chan, W., Ng, B. F., & Lam, L. C. (2007). Efficacy of aromatherapy (Lavandula angustifolia) as an intervention for agitated behaviours in Chinese older persons with dementia: A cross-over randomized trial. *International Journal of Geriatric Psychiatry,* 22(5), 405-410.

Bright light therapy

Burns, A., Allen, H., Tomenson, B., Duignan, D., & Byrne, J. (2009). Bright light therapy for agitation in dementia: A randomized controlled trial. *International Psychogeriatrics,* 21(4), 711-721.

Hickman, S. E., Barrick, A. L., Williams, C. S., et al. (2007). The effect of ambient bright light therapy on depressive symptoms in persons with dementia. *Journal of the American Geriatrics Society,* 55(11), 1817-1824.

Royer, M., Ballentine, N. H., Eslinger, P. J., et al. (2012). Light therapy for seniors in long term care. *Journal of the American Medical Directors Association,* 13(2), 100-102.

Snoezelen

Van Weert, J. C. M., Van Dulmen, A. M., Spreeuwenberg, P. M. M., et al. (2005). Behavioral and mood effects of snoezelen integrated into 24-hour dementia care. *Journal of the American Geriatrics Society,* 53(1), 24-33.

Music and arts

Art therapy and craft

Greaves, C. J., & Farbus, L. (2006). Effects of creative and social activity on the health and well-being of socially isolated older people: Outcomes from a multi-method observational study. *The Journal of the Royal Society for the Promotion of Health,* 126(3), 134-142.

Okumiya, K., Morita, Y., Nishinaga, M., et al. (2005). Effects of group work programs on community-dwelling elderly people with age-associated cognitive decline and/or mild depressive moods: A Kahoku Longitudinal Aging study. *Geriatrics & Gerontology International,* 5(4), 267-275.

Rusted, J., Sheppard, L., & Waller, D. (2006). A multi-centre randomized control group trial on the use of art therapy for older people with dementia. *Group Analysis,* 39(4), 517-536.

Dance and movement

Alpert, P. T., Miller, S. K., Wallmann, H., et al. (2009). The effect of modified jazz dance on balance, cognition, and mood in older adults. *Journal of the American Academy of Nurse Practitioners,* 21(2), 108-115.

Guzman-Garcia, A., Hughes, J., James, I., & Rochester, L. (2013). Dancing as a psychosocial intervention in care homes: A systematic review of the literature. *International Journal of Geriatric Psychiatry,* 28(9), 914-924.

Haboush, A., Floyd, M., Caron, J., et al. (2006). Ballroom dance lessons for geriatric depression: An exploratory study. *The Arts in Psychotherapy* 33, 89-97.

Music and singing

Chu, H., Yang, C. Y., Lin, Y., et al. (2014). The impact of group music therapy on depression and cognition in elderly persons with dementia: A randomized controlled study. *Biological Research for Nursing,* 16(2), 209-217.

Daly, M., Purchase, R., Quinn, L., & Doyle, C. (2013). *Forgotten notes: Pilot study of a choir for people living with dementia in residential care*. Melbourne: National Ageing Research Institute, report commissioned by Benetas.

Mohammadi, A. Z., Shahabi, T., & Panah, F. M. (2011). An evaluation of the effect of group music therapy on stress, anxiety, and depression levels in nursing home residents. *Canadian Journal of Music Therapy,* 17(1), 55-68.

Raglio, A., Bellelli, G., Traficante, D., et al. (2008). Efficacy of music therapy in the treatment of behavioral and psychiatric symptoms of dementia. *Alzheimer Disease and Associated Disorders,* 22(2), 158-162.

Särkämö, T., Tervaniemi, M., Laitinen, S., et al. (2013). Cognitive, emotional, and social benefits of regular musical activities in early dementia: Randomized controlled study. *The Gerontologist*. 54(4):634-50.

Sung, H. C., Lee, W. L., Li, T. L., & Watson, R. (2012). A group music intervention using percussion instruments with familiar music to reduce anxiety and agitation of institutionalized older adults with dementia. *International Journal of Geriatric Psychiatry,* 27(6), 621-627.

Social activities

Animals and pet therapy

le Roux, M. C., & Kemp, R. (2009). Effect of a companion dog on depression and anxiety levels of elderly residents in a long-term care facility. *Psychogeriatrics,* 9(1), 23-26.

Lutwack-Bloom, P., Wijewickrama, R., & Smith, B. (2005). Effects of pets versus people visits with nursing home residents. *Journal of Gerontological Social Work,* 44(3-4), 137-159.

Buddying and befriending

Mead, N., Lester, H., Chew-Graham, C., et al. (2010). Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *British Journal of Psychiatry,* 196(2), 96-101.

Intergenerational programs

Herrmann, D. S., Sipsas-Herrmann, A., Stafford, M., & Herrmann, N. C. (2006). Benefits and risks of intergenerational program participation by senior citizens. *Educational Gerontology,* 31(2), 123-138.

Men's sheds

Ballinger, M. L., Talbot, L. A., & Verrinder, G. K. (2009). More than a place to do woodwork: A case study of a community-based Men's Shed. *JMH,* 6(1), 20-27.

Flood, P., & Blair, S. (2013). Men's sheds in Australia: Effects on physical health and mental well-being. *beyondblue.* www.beyondblue.org.au/docs/default-source/research-project-files/bw0209.pdf?sfvrsn=2

Volunteering

Butler, S. S. (2006). Evaluating the senior companion program: A mixed-method approach. *Journal of Gerontological Social Work,* 47(1-2), 45-70.

Greenfield, E. A., & Marks, N. F. (2004). Formal volunteering as a protective factor for older adults' psychological well-being. *The Journals of Gerontology,* 59B(5), S258-264.

Lum, T. Y., & Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Aging,* 27(1), 31-55.

Musick, M. A., & Wilson, J. (2003). Volunteering and depression: the role of psychological and social resources in different age groups. *Social Science & Medicine,* 56(2), 259-269.

van der Ploeg, E. S., Mbakile, T., Genovesi, S., & O'Connor, D. W. (2012). The potential of volunteers to implement non-pharmacological interventions to reduce agitation associated with dementia in nursing home residents. *International Psychogeriatrics,* 24(11), 1790-1797.

Reflection

Life review

Bohlmeijer, E., Smit, F., & Cuijpers, P. (2003). Effects of reminiscence and life review on late-life depression: A meta-analysis. *International Journal of Geriatric Psychiatry,* 18, 1088-1094.

Mastel-Smith, B., Binder, B., Malecha, A., et al. (2006). Testing therapeutic life review offered by home care workers to decrease depression among home-dwelling older women. *Issues in Mental Health Nursing,* 27(10), 1037-1049.

Pinquart, M., & Forstmeier, S., (2012). Effects of reminiscence interventions on psychosocial outcomes: A meta-analysis. *Ageing & Mental Health,* 16, 541-558.

Symes, L., Mastel-Smith, B., Hersch, G., et al. (2007). The feasibility of home care workers delivering an intervention to decrease depression among home-dwelling, older women: A qualitative analysis. *Issues in Mental Health Nursing,* 28(7), 799-810.

Prayer and spiritual counselling

Haugan, G., & Innstrand, S. T. (2012). The effect of self-transcendence on depression in cognitively intact nursing home patients. *ISRN Psychiatry, 2012*, 301325.

Lloyd, M. (2003). Innovations in care. Challenging depression: taking a spiritually enhanced approach. *Geriaction,* 21(4), 26-29.

Lo, C., Lin, J., Gagliese, L., et al. (2010). Age and depression in patients with metastatic cancer: the protective effects of attachment security and spiritual wellbeing. *Ageing and Society,* 30(2), 325-336.

Wang, J. J., Lin, Y. H., & Hsieh, L. Y. (2011). Effects of gerotranscendence support group on gerotranscendence perspective, depression, and life satisfaction of institutionalized elders. *Aging & Mental Health,* 15(5), 580-586.

White, J. (2004). Spiritual and pastoral care approaches for helping older adults with depression. *Journal of Religion, Spirituality & Aging,* 16(3-4), 91-107.

Simple reminiscence

Bohlmeijer, E., Smit, F., & Cuijpers, P. (2003). Effects of reminiscence and life review on late-life depression: A meta-analysis. *International Journal of Geriatric Psychiatry,* 18, 1088-1094.

Pinquart, M., & Forstmeier, S., (2012). Effects of reminiscence interventions on psychosocial outcomes: A meta-analysis. *Ageing & Mental Health,* 16, 541-558.

Woods, B., Spector, A., Jones, C., et al. (2005). Reminiscence therapy for dementia. *Cochrane Database of Systematic Reviews,* 18(2), CD001120

Education and skills training

Bibliotherapy and self-help

Cuijpers, P., van Straten, A., & Smit, F. (2006). Psychological treatment of late-life depression: A meta-analysis of randomized controlled trials. *International Journal of Geriatric Psychiatry,* 21(12), 1139-1149.

Gregory, R. J., Schwer Canning, S., Lee, T. W., & Wise, J. C. (2004). Cognitive bibliotherapy for depression: A meta-analysis. *Professional Psychology: Research and Practice, 35*(3), 275-280.

Cognitive and memory skills interventions

Clare, L. P., Linden, D. E. J. D., Woods, R. T. M., et al. (2010). Goal-oriented cognitive rehabilitation for people with early-stage Alzheimer disease: A single-blind randomized controlled trial of clinical efficacy. *The American Journal of Geriatric Psychiatry,* 18(10), 928-939.

Kinsella, G. J., Mullaly, E., Rand, E., et al. (2009). Early intervention for mild cognitive impairment: A randomised controlled trial. *Journal of Neurology, Neurosurgery & Psychiatry,* 80(7), 730-736.

Simon, S. S., Yokomizo, J. E., & Bottino, C. M. C. (2012). Cognitive intervention in amnestic mild cognitive impairment: A systematic review. *Neuroscience & Biobehavioral Reviews,* 36(4), 1163-1178.

Sitzer, D. I., Twamley, E. W., & Jeste, D. V. (2006). Cognitive training in Alzheimer's disease: A meta-analysis of the literature. *Acta Psychiatrica Scandinavica,* 114(2), 75-90.

Interventions that rely on technology

Computer-aided therapy and computer games

Dear, B. F., Zou, J., Titov, N., et al. (2013). Internet-delivered cognitive behavioural therapy for depression: A feasibility open trial for older adults. *Australian and New Zealand Journal of Psychiatry,* 47, 169-176.

Preschl, B., Wagner, B., Forstmeier, S., & Maercker, A. (2011). E-health interventions for depression, anxiety disorder, dementia, and other disorders in older adults: A review. *Journal of CyberTherapy and Rehabilitation,* 4, 371-385.

Wollersheim, D., Merkes, M., Shields, N., et al. (2010). Physical and psychosocial effects of Wii video game use among older women. *International Journal of Emerging Technologies and Society,* 8(2), 85-98.

Yamaguchi, H., Maki, Y., & Takahashi, K. (2011). Rehabilitation for dementia using enjoyable video-sports games. *International Psychogeriatrics,* 23(4), 674-676.

Zou, J., Dear, B. F., Titov, N., et al. (2012). Brief internet-delivered cognitive behavioral therapy for anxiety in older adults: A feasibility trial. *Journal of Anxiety Disorders,* 26, 650-655.

Phone and telemonitoring

Brenes, G. A., Danhauer, S. C., Lyles, M. F., & Miller, M. E. (2014). Telephone-delivered psychotherapy for rural-dwelling older adults with generalized anxiety disorder: study protocol of a randomized controlled trial. *BMC Psychiatry,* 14, 34.

Cartwright, M., Hirani, S. P., Rixon, L., et al. (2013). Effect of telehealth on quality of life and psychological outcomes over 12 months (Whole Systems Demonstrator telehealth questionnaire study): nested study of patient reported outcomes in a pragmatic, cluster randomised controlled trial. *BMJ,* 346, f653.

Phillips, R., Schneider, J., Molosankwe, I., et al. (2014). Randomized controlled trial of computerized cognitive behavioural therapy for depressive symptoms: effectiveness and costs of a workplace intervention. *Psychological Medicine,* 44(4), 741-752.

Sundsli, K., Söderhamn, U., Espnes, G., & Söderhamn, O. (2014). Self-care telephone talks as a health-promotion intervention in urban home-living persons 75+ years of age: A randomized controlled study. *Clinical Interventions in Aging,* 9, 95-103.

Zautra, A. J., Davis, M. C., Reich, J. W., et al. (2012). Phone-based interventions with automated mindfulness and mastery messages improve the daily functioning for depressed middle-aged community residents. *Journal of Psychotherapy Integration,* 22(3), 206-228.

Robot companion

Bemelmans, R., Gelderblom, G. J., Spierts, N., et al. (2013). Development of robot interventions for intramural psychogeriatric care. *GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry,* 26(2), 113-120.

Heerink, M., Krose, B., Wielinga, B., & Evers, V. (2008, March 12-15). *Enjoyment, intention to use and actual use of a conversational robot by elderly people.* Paper presented at the 3rd ACM/IEEE International Conference on Human Robot Interaction, Amsterdam.

Kachouie, R., Sedighadeli, s., Khosla, R., & Chu, M.-T. (2014). Socially assistive robots in elderly care; A mixed-method systematic literature review. International Journal of Human-Computer Interaction, 30, 369-393.

Robinson, H., Macdonald, B., Kerse, N., & Broadbent, E. (2013). The psychosocial effects of a companion robot: A randomized controlled trial. *Journal of the American Medical Directors Association,* 14(9), 661-667.

Wada, K., Shibata, T., Saito, T., et al. (2005). A progress report of long-term robot assisted activity at a health service facility for the aged. *Annual Review of CyberTherapy and Telemedicine,* 3, 179-183.

Simulated presence therapy

Bayles, K. A., Chapman, S. B., Cleary, S. J., et al. (2006). Evidence-based practice recommendations for working with individuals with dementia: simulated presence therapy. *Journal of Medical Speech – Language Pathology,* 14, xiii+.

Cheston, R., Thorne, K., Whitby, P., & Peak, J. (2007). Simulated presence therapy, attachment and separation amongst people with dementia. *Dementia,* 6(3), 442-449.

O'Connor, C. M., Smith, R., Nott, M. T., et al. (2011). Using video simulated presence to reduce resistance to care and increase participation of adults with dementia. *American Journal of Alzheimer's Disease and Other Dementias,* 26(4), 317-325.

Peak, J. S., & Cheston, R. I. L. (2002). Using simulated presence therapy with people with dementia. *Aging & Mental Health,* 6(1), 77-81.

Quality of life approaches

Behavioural activation and pleasant events

Brooker, D. J., Argyle, E., Scally, A. J., & Clancy, D. (2011). The Enriched Opportunities Programme for people with dementia: A cluster-randomised controlled trial in 10 extra care housing schemes. *Aging & Mental Health,* 15(8), 1008-1017.

Cernin, P. A., & Lichtenberg, P. A. (2009). Behavioral treatment for depressed mood: A pleasant events intervention for seniors residing in assisted living. *Clinical Gerontologist,* 32(3), 324-331.

Quijano, L. M., Stanley, M. A., Petersen, N. J., et al. (2007). Healthy IDEAS: A depression intervention delivered by community-based case managers serving older adults. *Journal of Applied Gerontology,* 26(2), 139-156.

Samad, Z., Brealey, S., & Gilbody, S. (2011). The effectiveness of behavioural therapy for the treatment of depression in older adults: A meta-analysis. *International Journal of Geriatric Psychiatry,* 26(12), 1211-1220.

Wood, A. H., & Alberta, A. J. (2009). A community-driven behavioral health approach for older adults: Lessons learned. *Journal of Community Psychology,* 37(5), 663-669.

Dementia care mapping

Brooker, D. (2005). Dementia Care Mapping: A review of the literature. *Gerontologist,* 45, Special issue 1, 11-18.

Person-centred care

Ballard, C., & Aarsland, D. (2009). Person-centred care and care mapping in dementia. *The Lancet Neurology,* 8(4), 302-303.

Chenoweth, L., King, M. T., Jeon, Y. H., et al. (2009). Caring for Aged Dementia Care Resident study (CADRES) of Person-Centred Care, Dementia-Care MApping, and Usual Care in Dementia: A Cluster-randmised trial. *The Lancet Neurology,* 8(4), 317-325.

Fossey, J., Ballard, C., Juszczak, E., et al. (2006). Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: Cluster randomised trial. *BMJ,* 332, 756-762.

Restorative approaches

Galik, E. M., Resnick, B., Gruber-Baldini, A., et al. (2008). Pilot testing of the restorative care intervention for the cognitively impaired. *Journal of the American Medical Directors Association,* 9(7), 516-522.

Graff, M. J., Vernooij-Dassen, M. J., Thijssen, M., et al. (2007). Effects of community occupational therapy on quality of life, mood, and health status in dementia patients and their caregivers: A randomized controlled trial. *Journals of Gerontology Series A-Biological Sciences & Medical Sciences,* 62(9), 1002-1009.

Lewin, G., & Vandermeulen, S. (2010). A non-randomised controlled trial of the Home Independence Program (HIP): An Australian restorative programme for older home-care clients. *Health and Social Care in the Community* 18, 91–99.

Lewin, G., De San Miguel, K., Knuiman, M., et al. (2013). A randomised controlled trial of the Home Independence Program (HIP), an Australian restorative home care programme for older adults. *Health and Social Care in the Community,* 21(1), 69-78.

Mozley, C., Schneider, J., Cordingley, L., et al. (2007). The care home activity project: Does introducing an occupational therapy programme reduce depression in care homes? *Aging & Mental Health,* 11(1), 99-107.

Interventions for carers

Education, social support, and skill building

Livingston, G., Barber, J., Rapaport, P., Knapp, M., Griffin, M., King, D., . . . Cooper, C. (2013). Clinical effectiveness of a manual based coping strategy programme (START, STrAtegies for RelaTives) in promoting the mental health of carers of family members with dementia: pragmatic randomised controlled trial. *BMJ,* 347.

Lopez, J., Crespo, M., & Zarit, S. H. (2007). Assessment of the efficacy of a stress management program for informal caregivers of dependent older adults. *The Gerontologist,* 47(2), 205-214.

Interventions that rely on technology

Mahoney, D., Tarlow, B. J., & Jones, R. N. (2003). Effects of an automated telephone support system on caregiver burden and anxiety: Findings from the REACH for TLC intervention study. *The Gerontologist,* 43(4), 556-567.

Mindfulness-based approaches

Whitebird, R. R., Kreitzer, M., Crain, A. L., et al. (2013). Mindfulness-based stress reduction for family caregivers: A randomized controlled trial. *The Gerontologist,* 53(4), 676-686.

Psychological interventions and counselling

Boots, L. M. M., de Vugt, M. E., van Knippenberg, R. J. M., et al. (2014). A systematic review of Internet-based supportive interventions for caregivers of patients with dementia. *International Journal of Geriatric Psychiatry,* 29(4), 331-344.

Gitlin, L. N., Belle, S. H., Burgio, L. D., et al. (2003). Effect of multicomponent interventions on caregiver burden and depression: The REACH Multisite Initiative at 6-month follow-pp. *Psychology & Aging,* 18(3), 361-374.

Lopez, J., & Crespo, M. (2008). Analysis of the efficacy of a psychotherapeutic program to improve the emotional status of caregivers of elderly dependent relatives. *Aging & Mental Health,* 12(4), 451-461.

Moore, R., Chattillion, E., Ceglowski, J., et al. (2013). A randomized clinical trial of Behavioral Activation (BA) therapy for improving psychological and physical health in dementia caregivers: Results of the Pleasant Events Program (PEP). *Behaviour and Research* 51(10), 623-632.

Mixed interventions

Belle, S. H., Burgio, L., Burns, R., et al. (2006). Enhancing the quality of life of dementia caregivers from different ethnic or racial groups. A randomized, controlled trial. *Annals of Internal Medicine,* 145(10), 727-738.

Haley, W. E., Bergman, E. J., Roth, D. L., et al. (2008). Long-term effects of bereavement and caregiver intervention on dementia caregiver depressive symptoms. *The Gerontologist,* 48(6), 732-740.

Huynh-Hohnbaum, A.-L. T., Villa, V. M., Aranda, M. P., & Lambrinos, J. (2008). Evaluating a multicomponent caregiver intervention. *Home Health Care Services Quarterly: The Journal of Community Care,* 27(4), 299-325.

Pillemer, K., & Suitor, J. J. (2002). Peer support for Alzheimer's caregivers: Is it enough to make a difference? *Research on Aging,* 24(2), 171-192.

Toseland, R. W., McCallion, P., Smith, T., & Banks, S. (2004). Supporting caregivers of frail older adults in an HMO Setting. *American Journal of Orthopsychiatry,* 74(3), 349-364.

Interventions delivered by mental health professionals

Acceptance and commitment therapy

Loebach Wetherill, J., Afari, N., Ayers, C. R., et al. (2011). Acceptance and commitment therapy for generalized anxiety disorder in older adults: A preliminary report. *Behavior Therapy,* 42, 127-134.

Cognitive behaviour therapy

Floyd, M., Scogin, F., McKendree-Smith, N. L., et al. (2004). Cognitive therapy for depression: A comparison of individual psychotherapy and bibliotherapy for depressed older adults. *Behavior Modification,* 28(2), 297-318.

Hyer, L., Yeager, C. A., Hilton, N., & Sacks, A. (2009). Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care. *American Journal of Alzheimer's Disease and Other Dementias,* 23(6), 528-539.

Konnert, C., Dobson, K., & Stelmach, L. (2009). The prevention of depression in nursing home residents: A randomized clinical trial of cognitive-behavioral therapy. *Aging & Mental Health,* 13(2), 288-299.

Laidlaw, K., Davidson, K., Toner, H., et al. (2008). A randomised controlled trial of cognitive behaviour therapy vs treatment as usual in the treatment of mild to moderate late life depression. *International Journal of Geriatric Psychiatry,* 23(8), 843-850.

Wilson, K., Mottram, W., & Vassilas, C. (2008). Psychotherapeutic treatments for older depressed people. *Cochrane Database of Systematic Reviews*, 1, Art. No.: CD004853.

Interpersonal psychotherapy

Borge, F. M., Hoffart, A., & Sexton, H. (2010). Predictors of outcome in residential cognitive and interpersonal treatment for social phobia: do cognitive and social dysfunction moderate treatment outcome? *Journal of Behavior Therapy & Experimental Psychiatry,* 41(3), 212-219.

Heisel, M. J., Duberstein, P. R., Talbot, N. L., et al. (2009). Adapting interpersonal psychotherapy for older adults at risk for suicide: Preliminary findings. *Professional Psychology: Research and Practice,* 40(2), 156-164.

Hinrichsen, G. A. (2008). Interpersonal psychotherapy for late life depression: Current status and new applications. *Journal of Rational-Emotive & Cognitive-Behavior Therapy,* 26(4), 263-275.

Miller, M. (2008). Using interpersonal therapy (IPT) with older adults today and tomorrow: A review of the literature and new developments. *Current Psychiatry Reports,* 10(1), 16-22.

Life review therapy

Chiang, K.-J., Chu, H., Chang, H.-J., et al. (2010). The effects of reminiscence therapy on psychological well-being, depression, and loneliness among the institutionalized aged. *International Journal of Geriatric Psychiatry,* 25(4), 380-388.

Jones, E. D. (2003). Reminiscence therapy for older women with depression. Effects of nursing intervention classification in assisted-living long-term care. *Journal of Gerontological Nursing,* 29(7), 26-33.

Karimi, H., Dolatshahee, B., Momeni, K., et al. (2010). Effectiveness of integrative and instrumental reminiscence therapies on depression symptoms reduction in institutionalized older adults: An empirical study. *Aging & Mental Health,* 14(7), 881-887.

Stinson, C. K., Young, E. A., Kirk, E., & Walker, R. (2010). Use of a structured reminiscence protocol to decrease depression in older women. *Journal of Psychiatric & Mental Health Nursing,* 17(8), 665-673.

Wang, J.-J. (2007). Group reminiscence therapy for cognitive and affective function of demented elderly in Taiwan. *International Journal of Geriatric Psychiatry,* 22(12), 1235-1240.

Mindfulness-based approaches

Evans, S., Ferrando, S., Findler, M., et al. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders,* 22(4), 716-721.

Gallegos, A. M., Hoerger, M., Talbot, N. L., et al. (2013). Emotional benefits of mindfulness-based stress reduction in older adults: The moderating roles of age and depressive symptom severity. *Aging & Mental Health,* 17(7), 823-829.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting & Clinical Psychology,* 78(2), 169-183.

Kitsumban, V., Thapinta, D., Sirindharo, P. B., & Anders, R. L. (2009). Effect of cognitive mindfulness practice program on depression among elderly Thai women. *Thai Journal of Nursing Research,* 13(2), 95-107.

Lindberg, D. A. (2005). Integrative review of research related to meditation, spirituality, and the elderly. *Geriatric Nursing,* 26(6), 372-377.

Owens, G. P., Walter, K. H., Chard, K. M., & Davis, P. A. (2012). Changes in mindfulness skills and treatment response among veterans in residential PTSD treatment. *Psychological Trauma: Theory, Research, Practice, and Policy,* 4(2), 221-228.

Narrative therapy

Kropf, N. P., Tandy, C. (1998). Narrative therapy with older clients: The use of a "meaning-making" approach. *Clinical Gerontologist,* 18, 3-16.

Poole, J., Gardner, P., Flower, M. C., & Cooper, C. (2009). Narrative therapy, older adults, and group work?: Practice, research, and recommendations. *Social Work with Groups,* 32 (4), 288-302.

Problem-solving therapy

Alexopoulos, G. S., Raue, P., & Arean, P. (2003). Problem-solving therapy versus supportive therapy in geriatric major depression with executive dysfunction. *The American Journal of Geriatric Psychiatry,* 11(1), 46-52.

Ayalon, L., Bornfeld, H., Gum, A. M., & Arean, P. A. (2009). The use of problem-solving therapy and restraint-free environment for the management of depression and agitation in long-term care. *Clinical Gerontologist: The Journal of Aging and Mental Health,* 32(1), 77-90.

Gellis, Z. D., & Bruce, M. L. (2010). Problem-solving therapy for subthreshold depression in home healthcare patients with cardiovascular disease. *The American Journal of Geriatric Psychiatry,* 18(6), 464-474.

Gellis, Z. D., McGinty, J., Horowitz, A., et al. (2007). Problem-solving therapy for late-life depression in home care: A randomized field trial. *American Journal of Geriatric Psychiatry,* 15(11), 968-978.

Gellis, Z. D., McGinty, J., Tierney, L., et al. (2008). Randomized controlled trial of problem-solving therapy for minor depression in home care. *Research on Social Work Practice,* 18(6), 596-606.

Case study acknowledgements and permissions

Most case studies in this booklet have been edited and are shorter than the form in which they originally appeared.

Exercise

Page 23, left: Content for this case study has been adapted from Well for Life resources with permission from the Department of Health, Victoria. www.health.vic.gov.au/agedcare/downloads/wellforlife/ewb_resi_sheet36.pdf

Gardening and nature-assisted therapy

Page 25, right: Content for this case study has been adapted from Well for Life resources with permission from the Department of Health, Victoria. www.health.vic.gov.au/agedcare/downloads/wellforlife/ewb_home_sheet22.pdf

Page 25, left: Positive Living in Aged Care (PLAC) program funded by NSW Health and managed by Aged and Community Services Association NSW and ACT. Permission provided by Aged Care Co-ordinator, Balranald Hostel, NSW.

Laughter therapy and laughter yoga

Page 27: Case study provided by Dr Julie Ellis and Ros Ben-Moshe, with permission from Aged Care Services Australia Group (ACSAG). www.latrobe.edu.au/news/articles/2014/release/lol!-healing-powers-of-laughter

Tai chi and qigong

Page 29: Case study provided by Uniting AgeWell.

Yoga

Page 31: Permission granted by John Schlorholtz. john@agelessyoga.org

Humour therapy

Page 35: Permission to use The Elder Clowns™ case study provided by The Humour Foundation. www.humourfoundation.com.au

Massage

Page 37: Reprinted with permission from the September 2009 issue of Massage Today (Vol. 09, Issue 09), www.massagetoday.com

Meditation

Page 39: Case study provided by Basscare.

Aromatherapy

Page 44: Case study published with permission of the Australian Journal of Dementia Care and Bupa Aged Care – *Sensory Towels, 23 May 2013*. http://journalofdementiacare.com/333/

Art therapy and craft

Page 51, left: Case study provided by Uniting AgeWell.

Page 51, right: Text adapted from: Mandurah Mail, Friday October 17 2014 with permission provided by Amana Living.

Dance and movement

Page 53, left: Case study provided by Uniting AgeWell.

Page 53, right: Case study from *Exploring dance as a therapy for symptoms and social interaction in a dementia care unit*, Nursing times, 30/7/09 available at www.nursingtimes.net/nursing-practice/clinical-zones/mental-health/exploring-dance-as-a-therapy-for-symptoms-and-social-interaction-in-a-dementia-care-unit/5004646.article

Music and singing

Page 55, left: Case study provided by ACH group.

Page 55, right: Case study provided by Uniting AgeWell.

Animals and pet therapy

Page 59: Permission for use of case study and image provided by Delta Society. www.deltasociety.com.au

Buddying and befriending

Page 61: Permission to use case study provided by Red Cross. www.redcross.org.au/cvs-story-ivy-and-judy.aspx

Intergenerational programs

Page 63: Case study provided by Uniting AgeWell.

Men's Shed

Page 64: Case study provided by Uniting AgeWell.

Volunteering

Page 66: Case study and image provided by Feros Care.

Life review

Page 71: Case study provided by the Community Education Centre, Hawthorn, Victoria.

Prayer and spiritual counselling

Page 73, left: Case study provided by Uniting AgeWell.

Page 73, right: Content for this case study has been adapted from Well for Life resources with permission from the Department of Health, Victoria. www.health.vic.gov.au/agedcare/downloads/wellforlife/ewb_resi_complete.pdf

Simple reminiscence

Page 75: Case study provided by Ruth Hargrave and family, Samarinda Lodge, Ashburton Victoria.

Cognitive and memory skills

Page 7: Case study provided by Professor Glynda Kinsella, La Trobe University, Victoria.

Computer-aided therapy and computer games

Page 83, left: Acknowledgements and thanks to Drs Elizabeth Cyarto and Frances Batchelor from the National Ageing Research Institute (NARI). For more information go to www.nari.unimelb.edu.au

Page 83, right: Mindspot case study provided by Dr Nick Titov, Centre for Emotional Health, Department of Psychology, Macquarie University, NSW.

Robot companion

Page 86: case study and permission provided by Professor Rajiv Khosla and blueCross.

Behavioural activation and pleasant events

Page 91: Permission provided by Professor Dawn Brooker PhD CPsychol (clin) AFBPsS, Director of the Association for Dementia Studies, University of Worcester, Henwick Grove, Worcester, WR2 6AJ.

Page 92: Permission granted by author Susan McLaine. Article available at www.fightdementia.org.au/common/files/VIC/Susan_McLaine.pdf

Dementia care mapping

Page 94: 'Dementia care mapping' Nursing times, 19/9/06. available at www.nursingtimes.net/dementia-care-mapping/201154.article

Person-centred care

Page 96, top: Content for this case study has been adapted from Well for Life resources with permission from the Department of Health, Victoria. www.health.vic.gov.au/agedcare/downloads/wellforlife/ewb_resi_complete.pdf

Page 96, bottom: Case study provided by Bernie McCarthy, McCarthy Psychology Services.

Restorative approaches

Page 99, left: Content for this case study has been adapted from *Towards an enabling approach in community care*, with permission from the Department of Family and Community Services, NSW. www.adhc.nsw.gov.au/__data/assets/file/0010/233965/Better_Practice_Project_-_Discussion.pdf

Page 99, right: Content for this case study has been adapted from Home and Community Care Active Service Model resources with permission from the Department of Health, Victoria. www.health.vic.gov.au/hacc/projects/downloads/isabelle.pdf

Education, social support and skill building

Page 103: Case study provided by Alfred Health Carer Services, www.carersouth.org.au

Acceptance and commitment therapy

Page 111: Permission to adapt material for the case study provided by the authors and by Elsevier. www.sciencedirect.com/science/article/pii/S1077722911001441

Cognitive behaviour therapy

Page 113: Case study provided by the booklet's authors.

Life review therapy

Page 115: Case study provided by Dr Sunil Bhar, Deputy Chair, Psychological Sciences Course Convenor, Clinical Psychology, Swinburne University of Technology, Victoria.

Page 116: Case study used with permission of Dr Jojanneke Korte. For more information on Stories we live by: http://doc.utwente.nl/82296/1/thesis_J_Korte.pdf

Narrative therapy

Page 119: Case study provided by Bruce Perham, Let's Talk Differently, letstalkdifferently.com.au

Problem-solving therapy

Page 121: Reference: Gellis, Z. D., & Bruce, M.L. (2010). Problem-solving therapy for subthreshold depression in home healthcare patients with cardiovascular disease. *American Journal of Geriatric Psychiatry, 18*(6), 464-474.

beyondblue
Depression. Anxiety.

Where to find more information

beyondblue
www.beyondblue.org.au
Learn more about anxiety and depression, or talk it through with our Support Service.

1300 22 4636
Email or chat to us online at www.beyondblue.org.au/getsupport

mindhealth*connect*
www.mindhealthconnect.org.au
Access to trusted, relevant mental health care services, online programs and resources.

facebook.com/beyondblue **@beyondblue** **@beyondblueofficial**

Donate online www.beyondblue.org.au/donations